Supreme Court, U.S.
FILED
'99 183 JUL 27 1999
OFFICE OF THE CLERK

No.

IN THE

Supreme Court of the United States

MARY–LOUISE O'NEAL,

Petitioner,

v.

FHP, INC., LOMA LINDA FACULTY MEDICAL GROUP, INC. and BONNIE BARNES,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE CALIFORNIA SUPREME COURT

PETITION FOR A WRIT OF CERTIORARI

SHARON J. ARKIN
Counsel of Record
SHERNOFF, BIDART, DARRAS & ARKIN
Attorneys for Petitioner
600 South Indian Hill Boulevard
Claremont, California 91711
(909) 621-4935

154132

Counsel Press LLC
FORMERLY LUTZ APPELLATE SERVICES
(800) 274-3321 • (800) 359-6859

5hp

QUESTION PRESENTED

Did the California Court of Appeal correctly determine that Medicare administrative remedies were required to be exhausted by the enrollee of a Medicare-qualified health maintenance organization: (1) Where the enrollee was seeking damages only under state tort law claims; (2) Where the damages claimed arose solely from a delay in the provision of Medicare-mandated benefits, but not an ultimate denial of such benefits; or (3) Where the wrongfully-withheld benefits were benefits supplemental to the Medicare-mandated benefits?

TABLE OF CONTENTS

	Page
Question Presented	i
Table of Contents	ii
Table of Cited Authorities	v
Table of Appendices	viii
Opinions Below	1
Statement of Jurisdiction	2
Statutes Involved	4
Statement of the Case	5
Reasons for Granting the Writ	8
I. The California Court Incorrectly Interpreted A Federal Statute In Determining That Personal Injury Claims Arising From A Medicare HMO's Wrongful Refusal Of Or Delay In Providing, Benefits Are Subject To Medicare's Administrative Review Provisions.	8
A. Background Regarding Medicare HMOs	8

Contents

Page

B. The California Court Of Appeal Wrongfully Concluded That A Personal Injury Claim Arising From The Denial Of Medicare Benefits Is Subject To Medicare's Administrative Review Requirements 12

C. The *Redmond* Decision Was Erroneously Decided And, Because It Is Leading Other Courts Astray, Certiorari Should Be Granted To Correct The Law As Misapplied By The California Courts 19

1. The *Redmond* court misquoted the applicable statutory provisions. 20

2. The *Redmond* court ignored the fact that consequential damages cannot be remediated under the Medicare review process. 21

3. The *Redmond* court failed to conduct an adequate preemption analysis. 23

Contents

		Page
D.	The Appellate Court Erroneously Invoked Medicare's Administrative Review Provisions As To Benefits Which Do Not Fall Within The Parameters Of Medicare's Administrative Review Provisions In The First Instance	26
Conclusion		30

TABLE OF CITED AUTHORITIES

Page

Cases:

Ardary v. Aetna Health Plans, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408, 138 L. Ed. 2d 174, 65 U.S.L.W. 3798 (1997) ..... *passim*

Berman v. Abington Radiology Associates, Inc. 1997 WL 534804 (E.D. Pa. 1997) 3, 10, 18

Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667, 106 S. Ct. 2133, 90 L. Ed. 2d 623 (1986) 15

Heckler v. Ringer, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984) 14, 18, 19

Massachusetts Medical Soc. v. Dukakis, 815 F.2d 790 (1st Cir. 1987) 25

Plocica v. NYLCARE of Texas, Inc., 43 F. Supp. 2d 658 (N.D. Tex. 1999) 3, 10, 19

Podolsky v. First Healthcare Corp., 50 Cal. App. 4th 632 (1996) 11

Redmond v. Secure Horizons, Pacificare, Inc., 60 Cal. App. 4th 96, 70 Cal. Rptr. 2d 174 (1997) 3, 8, 19, 20, 21, 22, 23, 26, 30

Cited Authorities

Page

Solorzano v. Superior Court (FHP, Inc.), 10 Cal. App. 4th 1135, 13 Cal. Rptr. 2d 161 (1993) . . 9, 11, 23

Talbot v. Lucy Corr Nursing Home, 118 F.3d 215 (4th Cir. 1997) 3, 10, 17, 18

Wartenberg v. Aetna U.S. Healthcare, Inc., 2 F. Supp. 2d 273 (E.D. N.Y. 1998) 3, 10, 18, 21, 23

Winkler v. Interim Health Services Inc., 26 F. Supp. 2d 1026 (M.D. Tenn. 1999) 3, 10, 19

Zamora-Quezada v Health Texas, 34 F. Supp. 2d 433 (W.D. Tex. 1998) 3, 10, 19

Statutes:

5 U.S.C. § 8902(m)(1) 24

28 U.S.C.A. § 1257 4

29 U.S.C. § 1001, *et seq.* 23

29 U.S.C. § 1144(a) 24

42 U.S.C. § 405(g) 10, 24

42 U.S.C. § 1395ff 20, 21

42 U.S.C.A. § 1395mm 1, 2, 9, 24

Cited Authorities

	Page
42 U.S.C. § 1395mm(c)(2)(A)(ii)	28
42 U.S.C.A. § 1395mm(c)(5)(B)	4, 10
42 U.S.C. § 1395mm(i)(6)	21
Rule:	
United States Supreme Court Rule 10	4
Other Authorities:	
42 C.F.R. § 417.600	26
42 C.F.R. § 417.606(b)	10, 27
42 C.F.R. § 417.606(b)(2)	11
42 C.F.R. § 417.606(c)	26
42 C.F.R. § 417.612	26
42 C.F.R. §§ 417.614-417.626	26
http:\\www.medicaid.com\ medicare\mpsct1.htm.	2

TABLE OF APPENDICES

Page

Appendix A — Opinion Of The State Of California Court Of Appeal For The Fourth District, Division Two Dated And Filed February 5, 1999 ..... 1a

Appendix B — Notice Of Entry Of Judgment Dated December 5, 1997 And Filed December 9, 1997 ..... 12a

Appendix C — Order Of The Supreme Court Of California For The Fourth Appellate District, Division Two Denying Petition For Review Dated And Filed April 28, 1999 ..... 17a

Petitioner Mary-Louise O'Neal respectfully prays that a writ of certiorari issue to review the judgment of the Supreme Court of the State of California filed on April 28, 1999, which became final on May 28, 1999. The Supreme Court denied review of the decision of the Court of Appeal of the State of California, Fourth Appellate District, Division Two, which was issued on February 5, 1999. The appellate court's decision held that the enrollee of a Medicare-qualified health maintenance organization is required to submit all her claims to Medicare's administrative review procedures pursuant to 42 U.S.C.A. § 1395mm, even where those claims are solely for state law tort damages, where the injuries for which damage is claimed arose from the delay in provision of Medicare-mandated benefits which were ultimately provided and where the delay and denial related to benefits provided under the HMO's plan which were supplemental to the Medicare-mandated benefits. The California Supreme Court refused to review the decision of the appellate court and that decision is contrary to every federal case – both appellate court level and district court level – decided in this country. The California state court's decision has the practical effect of stripping every California Medicare-HMO member of their right to state tort remedies in abrogation of Congress's intent to protect Medicare enrollees.

OPINIONS BELOW

The unpublished April 28, 1999 order of the Supreme Court of the State of California in this matter which gives rise to this petition is entitled *Mary-Louise O'Neal v. FHP, Inc., et al.* A copy of that order is reprinted in Appendix C hereto. The decision of the Court of Appeal of the State of California, Fourth Appellate District, Division Two, review of which was denied in the Supreme Court's order, is

reprinted in Appendix A. The judgment of dismissal of the Superior Court of the State of California from which the appeal to the appellate court was taken is reprinted in Appendix B.

STATEMENT OF JURISDICTION

On April 28, 1999, the Supreme Court of the State of California denied review of the decision rendered by the Court of Appeal of the State of California, Fourth Appellate District, Division Two.

Approximately 4 million of California's senior citizens are enrolled in Medicare. Of those, approximately 1.5 million have elected to receive their Medicare benefits through enrollment in managed care plans or health maintenance organizations ("HMOs"). (Data as of March, 1997, see http:\\www.medicaid.com\ medicare\mpsct1.htm.) HMOs are allowed to provide Medicare benefits to qualified senior citizens as the result of federal legislation included in Part D of the Medicare Act. (42 U.S.C. § 1395mm.)

Under the Medicare Act, a claim for benefits against an HMO is subject to Medicare's administrative review process. But several federal court cases, construing and applying the Medicare Act, have held that tort claims arising from an HMO's failure to provide benefits under its contract with its senior-care members are not subject to Medicare's administrative review provisions. Those courts, including both the Fourth and Ninth Circuit Courts of Appeals, examined both the language and history of the Medicare Act, its administrative review provisions and the specific portion of the Act dealing with HMO contracts and concluded that the administrative review provisions were explicitly intended

to address only the "quite minor matters" relating to "amount determinations" for benefits that were denied and was never intended to apply to state law-based tort claims for damages arising from a wrongful denial of benefits.[1]

Despite the existence of that extensive federal law construing a federal statute, the Court of Appeal of the State of California, Sixth District held in *Redmond v. Secure Horizons, Pacificare, Inc.* (1997) 60 Cal. App. 4th 96, 70 Cal. Rptr. 2d 174 that all claims, irrespective of whether they are claims for benefits or tort claims, must be subjected to the Medicare administrative review process. As discussed in detail below, the *Redmond* court not only misused ellipses and misquoted a Medicare statute in order to support its erroneous conclusion, the decision also conflicts with the federal authority construing and applying this federal legislation, the decision conflicts with the regulations promulgated by the Department of Health and Human Services for implementation of the Medicare Act provisions relating to HMOs and, additionally, is internally inconsistent and illogical. In the present case, the Fourth District Court of Appeal, Division 2 also elected to ignore the federal cases construing this federal law and to instead follow the *Redmond* court's misplaced analysis.

---

1. Those cases include: *Ardary v. Aetna Health Plans of California Inc.*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408; *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215, n.1 (4th Cir. 1997); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273; *Berman v. Abington Radiology Associates, Inc.* 1997 WL 534804 (E.D. Pa. 1997); *Zamora-Quezada v Health Texas*, 34 F. Supp. 2d 433 (W.D. Tex. 1998); *Winkler v. Interim Health Services Inc.*, 26 F. Supp. 2d 1026 (M.D. Tenn. 1999); and *Plocica v. NYLCARE of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999).

Despite the clear error in the appellate court's decision and despite the overwhelming importance of the issue presented, the California Supreme Court refused to review the appellate court's decision – a decision which misapplies federal law and conflicts with every federal court case on the issue. Accordingly, jurisdiction of this Court to review the decision of the Supreme Court of the State of California is invoked under 28 U.S.C.A. § 1257 and Rules of the United States Supreme Court, Rule 10(b) and (c).

STATUTES INVOLVED

This case involves the interpretation of 42 U.S.C.A. § 1395mm(c)(5)(B), which provides as follows:

> A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, and in applying section 405(l) of

this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

STATEMENT OF THE CASE

In January 1995, MARY-LOUISE O'NEAL ("MARY-LOUISE"), a charming, active and independent 90-year-old lady, enrolled in FHP's senior-care health benefits plan. [Clerk's Transcript[2] 222, ¶ 1.] A year later, when she suffered a stroke while playing bingo at the "Old Timers" club, she became a statistic in the managed care system. [*Id.*] She became a victim of a deliberate and widespread program adopted and implemented by FHP to wrongfully and illegitimately minimize its members' use of skilled nursing facilities and rehabilitation benefits. [*Id.*]

After MARY-LOUISE's acute care needs resulting from the stroke had been addressed, FHP authorized transfer of MARY-LOUISE to a skilled nursing facility for rehabilitation. [*Id.*, ¶ 2.] Consistent with a pattern of conduct displayed in many other cases, however, FHP "evaluated" MARY-LOUISE within days of the transfer and determined that she had "plateaued" – i.e., that the rehabilitation therapy had done all for her that could be accomplished – and that she should essentially be "warehoused" in a convalescent hospital until she died. [*Id.*]

Fortunately for MARY-LOUISE, her son, Enos Doyle, refused to accept that determination, knowing full well that

---

2. Hereinafter, "CT."

his mother was in no shape to survive a convalescent hospital without continued skilled nursing care and further rehabilitation. [*Id.*, ¶ 3.] Mr. Doyle objected to the transfer and was finally able to convince FHP that further rehabilitation would not only be helpful, but was absolutely necessary. [*Id.*] But FHP was not convinced for long. The same pattern repeated itself over and over again: FHP would "evaluate" MARY-LOUISE and make a determination that she did not need further rehabilitation, Mr. Doyle would protest, FHP would retract its denial of further rehabilitation benefits and MARY-LOUISE would be allowed to eke out a few more days of the rehabilitation care she medically needed and was contractually entitled to have. [CT 222-223, ¶ 4] But the physical strain and emotional trauma MARY-LOUISE suffered as a result of this constant delay in receipt of her needed physical therapy and rehabilitative care slowed and impaired her physical recovery and deprived her of months of health and well-being. [*Id.*]

FHP's effort to impede MARY-LOUISE's access to rehabilitation was a calculated business decision based on its own financial interest. [*Id.*, ¶ 5.] Most simply, FHP denies rehabilitation benefits because, due to the member's age and lack of expected longevity, FHP thinks the member is simply not "worth" rehabilitating. [*Id.*, ¶ 6.]

The complaint in this action alleges clearly and unequivocally the factual basis demonstrating that MARY-LOUISE's claims are not subject to the administrative review requirements set forth in the Medicare Act in the first instance. [CT 228-230, ¶¶ 22-28.] For example, even under the Medicare Act and the regulatory provisions promulgated pursuant to it, an HMO may agree to provide care in excess of Medicare's specified minimum requirements and those

supplemental benefits are expressly not subject to Medicare's administrative review process. Similarly, a claim based on the delay in the provision of benefits, where the benefits were ultimately provided by the HMO, is also expressly excluded from the administrative review process under the applicable Medicare provisions. MARY-LOUISE's complaint alleges both of those circumstances, thus precluding the application of any administrative review process in the first place.

Moreover, the complaint also alleges – specifically and clearly – the facts demonstrating that, even if Medicare's administrative review provisions otherwise applied to MARY-LOUISE's claim for benefits, they patently do not apply to her tort claims for the physical and emotional injuries suffered as the result in the delay in the provision of those benefits.

Defendants demurred to MARY-LOUISE's complaint, contending that her claims were, in fact, subject to Medicare's administrative review process. MARY-LOUISE opposed that demurrer, citing to both California and federal authority demonstrating that her claims were not subject to Medicare administrative review. Despite the inapplicability of the Medicare review provisions to the claims in this case, the trial court sustained defendants' demurrers, without leave to amend, and dismissed the case on the basis that MARY-LOUISE had failed to exhaust her administrative remedies. [Appendix B; CT 552-556; Reporter's Transcript 12:4-7.] The appellate court affirmed that ruling [Appendix A] and the California Supreme Court denied review. [Appendix C.]

REASONS FOR GRANTING THE WRIT

The decisions in *Redmond* and this case impact and affect the rights of nearly one and one-half million California senior citizens and effectively strip them of their ability to hold HMOs accountable for the injuries inflicted on them when their HMOs wrongfully refuse to provide benefits. Obviously, this issue is of grave importance and is one that substantially – and negatively – impacts the rights of all Medicare HMO members to enforce their state law remedies. Since the decisions in *Redmond* and in this case not only conflict with the federal court cases construing the federal statutory scheme and are, in and of themselves, inherently illogical, and since this is an issue of ever-growing concern to the bench and the bar, review should be granted in order to protect all Medicare enrollees and to conform California's application of law in this context to the federal cases and the controlling federal statutes.

I.

THE CALIFORNIA COURT INCORRECTLY INTERPRETED A FEDERAL STATUTE IN DETERMINING THAT PERSONAL INJURY CLAIMS ARISING FROM A MEDICARE HMO'S WRONGFUL REFUSAL OF, OR DELAY IN PROVIDING, BENEFITS ARE SUBJECT TO MEDICARE'S ADMINISTRATIVE REVIEW PROVISIONS.

A. Background Regarding Medicare HMOs

Congress established a program in which the Department of Health and Human Services, through its administrative agency, the Health Care Financing Administration

("HCFA"), contracts with various HMOs to provide medical care to Medicare-eligible California senior and disabled citizens. [CT 225, ¶ 14.] (*See also* 42 U.S.C. § 1395mm; *Solorzano v. Superior Court (FHP, Inc.)*, 10 Cal. App. 4th 1135, 13 Cal. Rptr. 2d 161 (1993).)

Under that program, the Department of Health and Human Services pays to the contracting HMO 95% of the statistically-calculated average expenditure expected in the particular geographic area for each Medicare-eligible citizen. [CT 225-226, ¶ 15.] (*Id.*) In Southern California, the average expenditure calculated by the Department of Labor to be paid for eligible treatment, over the lifetime of a Medicare eligible person, is approximately $600 per month. [*Id.*]

This statistically-calculated amount necessarily encompasses the amount Medicare expects to pay for the anticipated medical treatment for each Medicare recipient over their lifetime, including both periods during which the recipient is well and during periods when the recipient suffers extensive medical problems, including cancer, heart attacks, strokes and the like. [CT 226, ¶ 16.]

Thus, for each Medicare enrollee, FHP is paid 95% of approximately $600 (*i.e.*, $570), whether the member is ill or not and whether the member is provided treatment or not. [*Id.*, ¶ 17.] The contracting HMOs are also required to permit the members to disenroll at any time, with the disenrollment effective on the first of the month following the request for disenrollment. [*Id.*] Upon disenrollment, the Medicare eligible recipient may either resume the standard Medicare entitlement or may enroll with another contracting HMO. [*Id.*]

Generally, an HMO senior-care member whose treatment requests are denied is required under 42 U.S.C. § 1395mm(c)(5)(B) to utilize the Medicare administrative review process set forth in 42 U.S.C. § 405(g).

But in two specific situations delineated by the regulations pursuant to the statute, a senior-care member who believes their treatment request has been wrongfully denied need not seek administrative review of that benefits decision through the standard Medicare claim review process: (1) Where the services were, in fact, furnished and the enrollee has no further obligation for payment; and (2) Where the services as to which there is a dispute are included in an optional supplemental plan providing coverage over and above the standard Medicare minimum requirements. (42 C.F.R. § 417.606(b).)

Additionally, several federal courts, including both the Fourth and Ninth Circuit Courts of Appeals, have determined that where the HMO senior-care member seeks tort damages against the HMO arising from the HMO's failure to provide benefits, those tort claims are not subject to administrative review. (*Ardary v. Aetna Health Plans*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408, 138 L. Ed. 2d 174, 65 U.S.L.W. 3798 (1997); *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215, n.1 (4th Cir. 1997); *Berman v. Abington Radiology Associates, Inc.*, 1997 WL 534804 (E.D. Pa. 1997); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D. N.Y. 1998); *Zamora-Quezada v Health Texas*, 34 F. Supp. 2d 433 (W.D. Tex. 1998); *Winkler v. Interim Health Services Inc.*, 26 F. Supp. 2d 1026 (M.D. Tenn. 1999); and *Plocica v. NYLCARE of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999.)

Two other California appellate court decisions are also in accord with that conclusion. (*Solorzano v. Superior Court (FHP, Inc.)*, 10 Cal. App. 4th 1135, 13 Cal. Rptr. 2d 161 (1993); *Podolsky v. First Healthcare Corp.*, 50 Cal. App. 4th 632 (1996).)

Each of those exceptions apply in this case:

- MARY-LOUISE's primary claim is for the personal injuries suffered by her as the result of defendants' unreasonable refusal to timely and consistently provide the benefits promised in defendants' contract with her.

- Over the course of MARY-LOUISE's treatment for recovery from her stroke, and only after extensive protest of FHP's decisions and submission of medical proof of the continuing need for rehabilitation was MARY-LOUISE able to obtain the rehabilitation care she needed. [CT 228, ¶ 22.] Thus, the bulk of the "benefits" owed to her under the FHP senior-care plan was ultimately provided. [*Id.*] In the process, however, FHP's unreasonable interim denials still resulted in financial damage and emotional distress damages which are recoverable in this action, but which are not subject to the Medicare review process.

- And, as specifically alleged in the operative complaint, "the treatment sought by plaintiff constituted benefits provided under the FHP plan but which were not provided under or required by Medicare [but] were promised by FHP in excess of the Medicare requirements." [CT 229, ¶ 27; emphasis added.] Thus, under 42 C.F.R. § 417.606(b)(2), administrative review of those decisions was not required.

Despite the fact that the claims at issue in this action do not fall within any Medicare administrative review requirement, and despite the fact that the federal courts have concluded that no administrative review requirement applies to a claim for tort damages – even where it arises from a denial of a benefit that would otherwise be subject to the administrative review process – the California Court of Appeal in this case relied on a wrongly-decided case issued by a different district of the California Court of Appeal and erroneously concluded that MARY-LOUISE's claims are subject to administrative review. That conclusion, however, is patently wrong and certiorari is desperately needed in order to assure that California's senior citizens' state law tort remedies are not improperly abrogated by an inappropriate application of Medicare's administrative review provisions. Indeed, a number of other similar cases – presenting these same issues – are presently working their way through the California courts and direction is needed from this Court on these issues in order to assure that every Medicare beneficiary's rights are protected.

B. The California Court Of Appeal Wrongfully Concluded That A Personal Injury Claim Arising From The Denial Of Medicare Benefits Is Subject To Medicare's Administrative Review Requirements

As set forth in section D, below, MARY-LOUISE's benefit claims are not subject to Medicare's administrative review provisions in the first instance because they are benefits which expressly fall outside the parameters for administrative review. But even if MARY-LOUISE's underlying benefit claims were, in fact, subject to Medicare's administrative review provisions, the appellate court's conclusion that she had to exhaust those administrative

review requirements prior to bringing her personal injury claims is wrong. Indeed, all the federal cases that have dealt with this issue are in accord: Tort claims do not fall within Medicare's administrative review requirements. Only one other case, a California state court case, has reached a contrary conclusion and, as discussed below, that case was wrongly decided.

The issue of whether a tort claim arising from a benefit denial by a Medicare HMO must be submitted to the Medicare administrative review process was first decided by the Ninth Circuit Court of Appeals in *Ardary v. Aetna Health Plans*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408, 138 L. Ed. 2d 174, 65 U.S.L.W. 3798 (1997).

In *Ardary*, the plaintiffs' wife and mother, Cynthia Ardary, enrolled in a senior care plan just like the one MARY-LOUISE was in at the time her claims arose. Mrs. Ardary suffered a heart attack and was transported to the small, local community hospital in Big Bear. The hospital there was simply unequipped to deal with her extremely serious condition, and the emergency room doctor requested approval from Aetna to have Mrs. Ardary airlifted to Loma Linda University Hospital. Despite knowing that the airlift transfer to Loma Linda was Mrs. Ardary's only chance of survival, Aetna refused the request. Mrs. Ardary died at Big Bear several hours later.

Mrs. Ardary's husband and children sued Aetna and its doctors group not only for wrongful death, but also for negligent and intentional infliction of emotional distress and fraud. After removing the action to federal court on the grounds that federal question jurisdiction existed under the

Medicare Act, Aetna then sought to dismiss the Ardarys' action on the basis that it was precluded by the failure to exhaust the administrative remedy provisions of the Medicare Act. The Ninth Circuit flatly rejected that argument, holding instead that state law tort claims against a private Medicare provider are not preempted by the Medicare Act, and, thus, that Medicare's administrative remedies need not be exhausted before those claims can be pursued in state court. The same result is mandated here.

The Ninth Circuit's discussion in *Ardary* centered on the language of the Medicare statute. That statute requires that claims "arising under" the Medicare Act be submitted to the administrative review process provided in the Act. Aetna argued there, as defendants did here, that the tort claims were subject to those administrative review provisions because all the damage claims "related to" the original denial of Medicare benefits. The Ninth Circuit rejected that analysis as an "over-inclusive reading of the 'arising under' language" of the statute. (*Ardary*, 98 F.3d at 499.) The court concluded that even applying the rule in *Heckler v. Ringer*, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984), and its progeny to the issue of whether state law tort claims are subject to Medicare's administrative review provisions inevitably results in the conclusion that they are not. This is because those claims necessarily "arise under" ***state common law rights***, *not* Medicare rights and thus did not fulfill the *Heckler v. Ringer* requirement that the complaint " 'include any claims in which "*both* the ***standing*** and *the substantive basis* for the presentation" of the claims' is the Act." (*Id.*, emphasis added.)

The *Ardary* court also distinguished the federal cases cited by defendants and relied on by the appellate court here,

rejecting the notion that the tort claims were "at bottom" claims for benefits or that the tort claims were "inextricably intertwined" with the contractual benefit claims:

> Contrary to Aetna and Arrowest's assertions, *Bodimetric* should not be taken to imply that private Medicare providers and their representatives cannot be held responsible in their individual capacity for tortious acts committed in the context of the denial of Medicare benefits. *The removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients*. Aetna and Arrowest's argument that the claims are "inextricably intertwined" with the claim that Cynthia was improperly denied benefits simply misapplies *Ringer* and *Bodimetric* on these facts.

Ardary, 98 F.3d at 501 (emphasis added).

The *Ardary* court's analysis also considered the issue of whether the underlying legislative intent of the Medicare statutes somehow supported the claim that significant state law rights were intended by Congress to be subsumed within Medicare's administrative review process. Concluding that it did not, the *Ardary* court quoted from this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 106 S. Ct. 2133, 90 L. Ed. 2d 623 (1986) which, in turn, quoted from the remarks of Sen. Bennett in passing the legislation:

> [T]he "legislative history of both the statute establishing the Medicare program and the 1972

> amendments thereto ***provides specific evidence of Congress' intent to foreclose review only of "amount determinations" — i.e., those "quite minor matters,"*** . . . remitted finally and exclusively to adjudication by private insurance carriers in a "fair hearing."

Ardary, 98 F.3d at 501 (emphasis added).

The explicit statement of congressional intent that only review of amount determinations were intended to be foreclosed by Medicare's administrative review provisions further requires the conclusion that those provisions do not apply in this case – or in any case asserting personal injury claims – since the action does not challenge any "amount determination." Rather, a personal injury claimant seeks the right to assert substantial and significant state law rights which, based on that congressional intent, cannot be preempted.

Further, the Ninth Circuit noted, "the state law claims are not 'inextricably intertwined' with the denial of benefits . . . because the Ardarys are at bottom not seeking to recover benefits." (*Ardary*, 98 F.3d at 500; emphasis added.) Here, too, a personal injury claimant, such as MARY-LOUISE, is, at bottom, not seeking to recover Medicare benefits.

The *Ardary* court also noted that in that case, administrative review would be useless because the retroactive payment of benefits after exhaustion of the administrative remedies would not remedy the injury. Similarly, an HMO cannot go back in time and undo the physical injury and emotional harm caused by its callous denial or delay of benefits it wrongfully withheld.

After concluding that the state law claims "do not 'arise under' the Act," the Ninth Circuit then considered the issue of whether, given that, any federal jurisdiction existed sufficient to avoid remand of the action – and concluded that none did:

> The Medicare statutes, as applied to an HMO contract, do not, of course, contain a preemption provision. . . . Because we hold that the Ardarys' state law claims do not "arise under" the Medicare Act, we must conclude that the action was improperly removed to federal court. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66, 107 S.Ct. 1542, 1547-48, 95 L.Ed.2d 55 (1987).

Id., 98 F.3d at 501-502.

The Ninth Circuit then ordered the action remanded to state court because the claims were not subject to Medicare administrative review requirements and there was, therefore, no federal question jurisdiction.

Since the decision in *Ardary* was issued, every federal court which has considered the issue in a published opinion has concurred in the *Ardary* court's analysis and held that personal injury or tort claims arising from the wrongful denial or delay in the provision of benefits to a Medicare HMO member are not subject to Medicare's administrative review process:

- *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997). In *Talbot*, the court held that exhaustion of federal Medicare remedies is not

required where the Medicare member is seeking damages resulting from a violation of the resident rights provisions of federal Medicare law. (*Talbot*, n.1.)

- *Berman v. Abington Radiology Associates, Inc.*, 1997 WL 534804 (E.D. Pa. 1997). In *Berman*, the plaintiff sued her physicians, their medical group and her Medicare HMO for negligence. Following this Court's test in *Heckler v. Ringer*, the *Berman* court found that state common law, not the Medicare Act, provided the standing and substantive basis for plaintiff's claims and that plaintiff's claim was not, therefore, inextricably intertwined with a claim for Medicare benefits and that the action did not, therefore, "arise under" the Medicare Act.

- *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D.N.Y. 1998). As noted by the Wartenberg court:

> although the Supreme Court read the "arising under" language of the Act broadly, it also explicitly recognized that not all cases are appropriate for the initial exhaustion of the administrative remedies provided under the Act. See *Heckler v. Ringer*, 466 U.S. at 618. The Court noted that if a claim was wholly collateral to a claim for benefits, and if the plaintiff made a colorable showing that his injury could not be remedied by the retroactive payment of benefits, administrative remedies would not be appropriate for such a case. . . . Furthermore, plaintiff's claims are collateral to a claim for benefits, since the standing

of the plaintiff's claims is rooted in state law causes of action, and not the Medicare Act, as was the case in Heckler.

- *Zamora-Quezada v. Health Texas*, 34 F. Supp. 2d 433 (W.D. Tex. 1998). In finding that the standing and substantive basis for the patients' claims under the Americans With Disabilities Act against their Medicare HMOs was not the Medicare Act, this court commented on the *Ardary* case as instructive.

- *Plocica v. NYLCARE of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999.) Here, as in *Ardary* and *Wartenberg*, the court found that the state law-based tort claims made by a Medicare enrollee against a Medicare HMO do not meet the *Heckler* test and do not implicate Medicare's administrative review provisions.

- *Winkler v. Interim Health Services Inc.*, 26 F. Supp. 2d 1026 (M.D. Tenn. 1999).

C. The *Redmond* Decision Was Erroneously Decided And, Because It Is Leading Other Courts Astray, Certiorari Should Be Granted To Correct The Law As Misapplied By The California Courts

In ruling that MARY-LOUISE's claims were all preempted by Medicare's administrative review provisions, the appellate court in this case relied on and quoted extensively from the decision in *Redmond v. Secure Horizons, Pacificare, Inc.*, 60 Cal. App. 4th 96, 70 Cal. Rptr. 2d 174 (1997). In Redmond, the Sixth District Court of Appeal concluded that the plaintiff's tort claims against a

Medicare HMO were preempted by Medicare's administrative review provisions and that those provisions precluded the state law tort claims. But the appellate court's reliance on *Redmond* was misplaced, both because *Redmond* does not apply factually and because *Redmond* is poorly reasoned and wrongly decided. Indeed, the *Redmond* court's analysis is defective on several different levels.

1. *The Redmond court misquoted the applicable statutory provisions.*

In an appalling misuse of ellipses, the *Redmond* court misquoted the applicable statutory language from the Medicare statute in order to support its erroneous conclusion that the Medicare administrative review process subsumed the tort claims at issue in the case before it. Even more appalling, the appellate court in this case adopted and perpetrated the *Redmond* court's misquotation – even after the error was pointed out to the appellate court at oral argument in this case.

In *Redmond*, the court quoted from 42 U.S.C. § 1395ff, subdivision (a), as follows:

> "The determination of whether an individual is entitled to benefits . . . and the determination of the amount of benefits . . . , and any other determination with respect to a claim for benefits . . . shall be made by the Secretary [of Health & Human Services] in accordance with regulations prescribed by him."

The problem is, when that section is reviewed in its entirety, the material contained in the excised portion of the

quoted statute reveals that ***section 1395ff does not apply to claims made against Medicare HMOs***. The excised references, in fact, specifically provide that section 1395ff applies *only* to claims made under Subpart A and Subpart B of the Medicare Act. The provisions that establish and regulate Medicare HMOs, however, appear in ***Subpart*** *D* of the Act, not Subparts A or B. Thus, by its creative – and illegitimate – use of ellipses, the *Redmond* court created language facially supporting its conclusion, but created that language out of a statutory provision which actually defeats its conclusion.

2. *The Redmond court ignored the fact that consequential damages cannot be remediated under the Medicare review process.*

In addition to misquoting the Medicare statutes in order to illegitimately support its conclusion, and in addition to unjustifiably rejecting the analysis of the *Ardary* court on the issue, the *Redmond* court also ignored the fact, acknowledged in both *Ardary* and *Wartenberg*, that the Medicare administrative review process can do nothing more than determine whether the benefits should have been provided – there is no mechanism for awarding damages caused by the wrongful denial of benefits.

The *Redmond* court cited to 42 U.S.C. § 1395mm(i)(6) as justification for requiring that the tort claims proceed to the administrative review process, in the apparent belief that the section somehow authorizes an award of tort damages by the Secretary of Health and Human Services. (*Redmond*, 60 Cal. App. 4th at 100-101, 70 Cal. Rptr. 2d at 176.) But the court's reliance on that section was wholly misplaced. Section 1395mm(i)(6) provides only for imposition of civil

money penalties, not damages. Moreover, those penalties are paid solely to the Secretary. Thus, that section cannot compensate a member for consequential damages caused by the HMO's misconduct.

The *Redmond* court attempted to distinguish itself from *Ardary* by asserting that, in *Ardary*, the Ninth Circuit concluded that the administrative remedies did not have to be exhausted because the member had died and payment would not remediate the harm. (*Redmond*, 60 Cal. App. 4th at 103-104, 70 Cal. Rptr. at 178.) The *Redmond* court reasoned, then, that where a member was merely seeking reimbursement of expenses incurred by the member in obtaining the denied treatment elsewhere, the reimbursement itself would suffice as remediation.

But that simplistic analysis overlooks the consequential harm – financial, physical and emotional – that results from an HMO's wrongful refusal to provide promised benefits. Assume, for example, that the member needed care that cost $150,000 and had to mortgage their home to obtain that care when the HMO wrongfully denied payment. Later reimbursement after administrative review would not remediate the financial harm suffered by the insured in incurring the costs of obtaining the loan or in making the interest payments made on it. Nor can the later reimbursement remediate the emotional toll such a situation creates. And if there is some adverse impact on the member's medical condition due to the delay in receiving the treatment, later reimbursement for the cost of the treatment itself cannot remediate that harm either.

And forcing the plaintiff in *Redmond* to administrative review in that case was a pointless exercise, since the HMO

had already reimbursed the plaintiff for the treatment expenses even before suit was filed and the plaintiff was suing solely for the recovery of consequential damages for injuries proximately caused by the wrongful initial denial and delay in providing the benefits. Since the HMO had already acknowledged its obligation for payment of the benefits, and had paid them, and since the administrative review process cannot compensate a member for the consequential damages caused by the HMO's wrongful conduct, there was, in reality, nothing to be reviewed in the administrative process.

To that extent, the *Redmond* decision is not only illogical and nonsensical, it represents an enormous waste of resources for the plaintiff, the defendant and the administrative review process as a whole.

3. The Redmond court failed to conduct an adequate preemption analysis.

The *Redmond* court's conclusion that Congress intended that the Medicare review process preempt any and all state law tort claims in any way related to the underlying Medicare claim is patently wrong in light of the congressional intent analysis of both *Ardary* and *Wartenberg*. In fact, the *Redmond* court failed to conduct any adequate preemption analysis in the first instance. But, as noted above, the *Solorzano* court did conduct that analysis and its decision demonstrates the fundamental errors in reasoning committed by the *Redmond* court.

Moreover, if Congress intended to usurp the state's police power to regulate the health and welfare issues relating to its citizens, it certainly knew how to do so, since it did just that in the context of the Employee Retirement Income Security Act, 29 U.S.C. § 1001, *et seq.* ("ERISA"). Comparing the

preemption language of ERISA, the Federal Employee Hospital Benefits Act ("FEHBA"), 5 U.S.C. § 8902(m)(1), and the Medicare statute demonstrates that Congress never intended to preempt state law tort claims by subjecting them to Medicare's administrative review process:

ERISA's preemption language is very broad: ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." (29 U.S.C. § 1144(a); emphasis added.)

Similarly, the language in the FEHBA statute provides that FEHBA "shall supersede and preempt any State or local law . . . to the extent inconsistent with such contractual provisions." (5 U.S.C. § 8902(m)(1); emphasis added.)

In contrast, under Medicare, the statute merely provides that "[a]ny individual, after any final decision of the Commissioner of Social Security . . . may obtain review of such decision by a civil action. . . . The court shall have the power to enter . . . a judgment affirming, modifying, or reversing the decision . . ." (42 U.S.C. § 405(g).)

Obviously, the complete preemption of "any and all State" laws under ERISA and FEHBA cannot compare to the very limited preemption language of Medicare's administrative review provisions. Nowhere in the Social Security Act or in the Medicare Act, as it applies to Medicare HMOs under section 1395mm, did Congress even implicitly attempt to preclude tort actions based on a Medicare HMO's wrongful conduct.

As concluded by the *Ardary* court:

> We find nothing in the legislative history [of the Medicare Act] to suggest that the Act was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA.

Ardary, 98 F.3d at 501.

And, in fact, preemption of tort claims under Medicare's administrative review process would undermine and defeat Congress's intent in enacting the Medicare statutes. In contrast to the situation in ERISA – where one of the primary goals was to establish a consistent regulatory framework in order to preserve the availability of plan funds – the Medicare Act's fundamental purpose is to assure that America's aged and disabled are provided with a minimum level of medical care. (*Massachusetts Medical Soc. v. Dukakis*, 815 F.2d 790, 794 (1st Cir. 1987) [the basic purpose of the Medicare Act is "to insure adequate medical care for the elderly"].)

Obviously, imposing tort liability on an HMO which wrongfully refuses to authorize treatment or care to which the member is entitled under Medicare and/or the member's contract with the HMO will not discourage or hamper the HMO's vigilance in assuring that appropriate care is provided as required under Medicare. On the contrary, potential liability for such damages will incentivize an HMO to provide the appropriate and proper level of promised benefits – and will assure that Congress's intent is fulfilled. But precluding a Medicare-HMO enrollee from obtaining consequential damages for the HMO's tortious wrongs by

forcing those claims to an administrative review process which cannot award damages for those injuries would encourage unwarranted denials of benefits – a result in direct conflict with Congress's intent.

The *Redmond* court unjustifiably ignored those facts and rendered a decision that is illogical and erroneous. And the appellate court in this case improperly followed the *Redmond* court's lead.

D. The Appellate Court Erroneously Invoked Medicare's Administrative Review Provisions As To Benefits Which Do Not Fall Within The Parameters Of Medicare's Administrative Review Provisions In The First Instance

In addition to the fact that MARY-LOUISE's tort-based damage claims are not subject to Medicare review requirements in any event, the appellate court's determination in this case is even more ominous given the fact that, even under Medicare's own provisions, the benefits MARY-LOUISE was seeking from FHP are not subject to Medicare's administrative review provisions in the first instance.

The regulations governing Medicare's administrative review process, as it applies to HMO's is set forth in 42 C.F.R. § 417.600. Under those provisions an "organization determination" is final unless reconsidered or appealed pursuant to sections 417.614 through 417.626, which embody the Medicare administrative review process to the extent it applies to HMOs. (42 C.F.R. § 417.612.) But a claim decision that does not fall within the definition of an organization determination is not subject to the administrative review provisions. (42 C.F.R. § 417.606(c).)

Thus, the determination of whether a claim for benefits is subject to the administrative review procedures turns on whether it is an "organization determination." In 42 C.F.R. § 417.606(b), the regulations specify what determinations are not considered to be "organization determinations:"

> (b) Actions that are not organization determinations. The following are not organization determinations for purposes of this subpart:
>
> > (1) A determination regarding services that were furnished by the HMO or CMP, either directly or under arrangement, for which the enrollee has no further obligation for payment.
> >
> > (2) A determination regarding services included in an optional supplemental plan (see § 417.440(b)(2)).

Both of the "non-organization determination" elements apply to the underlying claims in this case and preclude application of the administrative review provisions. First, the complaint nowhere claims that rehabilitation care MARY-LOUISE needed was not ultimately provided. Nor is there any allegation that MARY-LOUISE has any further obligation for payment of the rehabilitation care. In fact, to the contrary, the complaint specifically alleges that the claims at issue in this case fall within Medicare's definition of what is a non-organization determination and thus not subject to Medicare's review provisions. [CT 228, ¶¶ 23-25.]

The complaint specifically alleges the fact that the benefits at issue in this case were ultimately provided

[CT 228, ¶ 22] and alleges the fact that MARY-LOUISE has no further obligation to pay for those benefits. [CT 228, ¶ 24.] The claims at issue, therefore, relate to non-organization determinations that are not subject to Medicare's administrative review provisions. That being the case, the trial court's sustaining of the demurrers on that ground is erroneous.

Second, Medicare's regulations only set forth the minimum benefits an HMO must provide to its Medicare enrollees and, in fact, a Medicare-qualified HMO is allowed to provide even broader benefits. (42 U.S.C. § 1395mm(c)(2)(A)(ii).)

MARY-LOUISE's contract claim is not predicated on the care she should have received under Medicare, but the care she was entitled to under the contractual promises made by FHP to provide care over and above the care she was entitled to under the bare Medicare provisions. As alleged in paragraph 27 of the First Amended Complaint, FHP promised to provide MARY-LOUISE with more than just Medicare benefits:

> For example, under the FHP plan, irrespective of the parameters for Medicare approval of home health care, FHP promises to provide all medically-necessary in-hospital rehabilitation services, irrespective of the level of benefits and irrespective of the benefit guidelines imposed by Medicare. (See Exhibit A, p. 26.) Similarly, under the FHP plan, FHP promises to provide home health care and rehabilitation services when it is medically necessary and prescribed by an FHP physician, irrespective of the Medicare parameters.

[CT 229-230, ¶ 27.]

Under Medicare regulations, in order for physical or occupational therapy to be covered, that therapy must be provided only when "there is an expectation that the patient's condition will improve significantly in a reasonably (and generally predictable) period of time." (Medicare Explained (CCH, Inc. 1997) ¶ 381, p. 112.) But FHP promises far more. Indeed, in its benefit summary, FHP promises to provide full rehabilitation services, including physical therapy and occupational therapy whenever the services are authorized by an FHP Plan Physician. [CT 235, ¶ 44.] Thus, under FHP's promised benefits, the therapy is covered even if there is no showing that the patient's condition will significantly improve within a reasonable period of time – a distinct difference from the Medicare provision.

Tellingly, MARY-LOUISE was repeatedly denied benefits by FHP because she was not improving rapidly enough – i.e., FHP was applying the Medicare standard. But FHP had an obligation to provide MARY-LOUISE with more care than Medicare promised and it was that care – the therapy over and above that mandated by Medicare – which was denied to her and which is at issue in this action. That being the case, Medicare's administrative review provisions did not apply in the first instance. As such, the appellate court's conclusion that MARY-LOUISE must exhaust Medicare's administrative remedies is patently erroneous.

CONCLUSION

The *Redmond* court misquoted the Medicare statutes, misapplied the law, ignored federal cases interpreting a federal statute and erroneously imposed a federal administrative process by refusing to honor and apply the state's tort law – even in the absence of any possible basis for federal preemption. The danger represented by the *Redmond* case has become a reality – its erroneous analysis has now been followed by another court. It can only be expected that yet other courts will also follow *Redmond* and California's growing number of senior citizens who are enrolled in Medicare HMOs are entitled to have that error in California law corrected. The instant case presents the optimal opportunity for this Court to do precisely that and it is respectfully requested that certiorari be granted.

Respectfully submitted,

SHARON J. ARKIN
Counsel of Record
SHERNOFF, BIDART,
DARRAS & ARKIN
Attorneys for Petitioner
600 South Indian Hill Boulevard
Claremont, California 91711
(909) 621-4935

APPENDIX

APPENDIX A — OPINION OF THE STATE OF CALIFORNIA COURT OF APPEAL FOR THE FOURTH DISTRICT, DIVISION TWO DATED AND FILED FEBRUARY 5, 1999

COURT OF APPEAL, FOURTH DISTRICT
DIVISION TWO
STATE OF CALIFORNIA

E021602
(Super.Ct.No. SCV-35262)

MARY-LOUISE O'NEAL,

Plaintiff and Appellant,

v.

FHP, INC. et al.,

Defendants and Respondents.

OPINION

* * *

Plaintiff Mary-Louise O'Neal (herein "Plaintiff"), challenges the trial court's grant of a demurrer without leave to amend to her first amended complaint against defendants FHP Healthcare Corporation, Inc. (the "HMO"), Loma Linda Faculty Medical Group, Inc., Bonnie Barnes, Reche Canyon Rehabilitation and Health Care Center, and Cynthia M. Gleason (herein collectively referred to as "Defendants").

Appendix A

PROCEDURAL BACKGROUND AND FACTS[1]

In January 1995, at the age of 90, Plaintiff enrolled in the HMO's senior-care health benefits plan. One year later, she suffered a stroke. The HMO authorized her admittance to a skilled nursing facility for rehabilitation. During the course of her stay, the HMO conducted periodic evaluations of her condition. Following each evaluation, the HMO determined that Plaintiff had plateaued and recommended a transfer to a convalescent hospital. However, Plaintiff's son, Enos Doyle, refused to accept the HMO's recommendation and objected to each attempted transfer. In response to his objections, the HMO allowed Plaintiff to remain a little longer at the nursing facility.

By way of her first amended complaint, Plaintiff alleges that while she was a member of the HMO, she was not provided with rehabilitation therapy, physical therapy and skilled nursing services. On July 18, 1997, the HMO demurred to Plaintiff's first amended complaint on the grounds that Plaintiff failed to exhaust her administrative remedies. Subsequently, the other defendants joined in the demurrer.

On September 8, 1997, the trial court granted the demurrer stating, "[F]ederal law requires exhaustion of administrative remedies, . . . [¶] [t]he amended complaint

---

1. Because Plaintiff has appealed from the judgment entered following the trial court's granting Defendants' demurrer to the first amended complaint without leave to amend, we take our facts from those alleged in the amended complaint.

does not allege that plaintiff complied with the mandatory administrative provisions of the Medicare Act which was 42 U.S.C. 1395 and the applicable federal regulations . . . . [¶] . . . In this state, if a plaintiff has statutory administrative remedies available, she must pursue them before turning to the courts[.]" An order granting the demurrer and dismissing Plaintiff's action was filed on October 15, 1997. Plaintiff appealed.

STANDARD OF REVIEW

"Where a trial court sustains a demurrer without leave to amend, we review such action under the abuse of discretion standard. [Citation.] If there is a reasonable possibility that the pleading can be cured by an amendment, the trial court's ruling will be reversed. [Citation.] [¶] On review, we examine the Complaint's factual allegations to determine whether they state a cause of action on any available legal theory. [Citation.] We treat the demurrer as admitting all material facts which were properly pleaded. [Citation.] However, we will not assume the truth of contentions, deductions, or conclusions of fact or law [citation] and we may disregard any allegations that are contrary to the law or to a fact of which judicial notice may be taken. [Citation.]" (*Interinsurance Exchange* v. *Narula* (1995) 33 Cal.App.4th 1140, 1143.)

DISCUSSION

The primary issue to be decided in this appeal is whether the exclusive review provisions of Title XVIII of the federal Social Security Act, 42 United States Code section 1395

("Medicare Act"), apply. Plaintiff contends that they do not because (1) she ultimately received the rehabilitation treatment which is the basis for her claim, and (2) the benefits which she sought fell within the optional supplemental plan provision of the HMO, i.e., "she was entitled to . . . care *over and above* the care she was entitled to under the bare Medicare provisions." Defendants disagree, relying on the holding in *Redmond* v. *Secure Horizons, Pacificare, Inc.* (1997) 60 Cal.App.4th 96. We agree with Defendants.

"Federal law specifies the services which health maintenance organizations such as [the HMO] must provide to Medicare-eligible members such as [P]laintiff who are enrolled in Medicare-subsidized health care plans. (42 U.S.C. § 1395mm.) The authority to determine whether certain services are covered by such a plan has been vested by Congress in the Secretary of Health and Human Services. 'The determination of whether an individual is entitled to benefits . . . and the determination of the amount of benefits . . . , *and any other determination with respect to a claim for benefits* . . . shall be made by the Secretary [of Health and Human Services] in accordance with regulations prescribed by him.' (42 U.S.C. § 1395ff(a), italics added.) 'If the Secretary determines that an eligible organization with a contract wider this section . . . [¶] . . . fails substantially to provide medically necessary items and services that are required (under law or under the contract) . . . , if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual . . . [¶] . . . [¶] the Secretary may provide, in addition to any other remedies authorized by law, for [civil money penalties, suspension of enrollment of individuals or suspension of payment to the organization].' (42 U.S.C. § 1395mm(i)(6).)

Appendix A

"A claim which 'arises under' the Medicare Act must be brought before the Secretary through a multilevel administrative review process. This administrative review process (which was expressly set forth in the contract between plaintiff and defendant) provides the 'exclusive' remedy for such claims. (Sen.Rep. No. 404, 89th Congress, 1st Sess., (1965) reprinted in 1965 U.S. Code Cong. & Admin. News, at p. 1995.) *Judicial* review of such claims is available only after the claimant has pressed the claim through every level of the administrative review process to a 'final' decision by the Secretary and even then such review may only be obtained in *federal* court. (*Heckler* v. *Ringer* (1984) 466 U.S. 602, 605-606 . . . .) It follows that such claims are never within the jurisdiction of a state court." (*Redmond* v. *Secure Horizons Pacificare, Inc.*, *supra*, 60 Cal.App.4th 96, 100-101, original emphasis.)

In *Redmond*, plaintiff brought a bad faith action against her health maintenance organization based on its initial denial of coverage and subsequent delayed payment of her claim for reimbursement of health care expenses covered under her Medicare-subsidized agreement with it. The trial court found that it lacked subject matter jurisdiction, sustained defendant's demurrer without leave to amend, and entered judgment of dismissal. Plaintiff appealed and the appellate court affirmed. The appellate court found that plaintiff's causes of action were claims arising under the Medicare Act, and had to be brought through a multilevel administrative review process that provides the exclusive remedy for such claims. Further, judicial review could only be obtained in federal court.

Here, as in *Redmond*, the trial court concluded that it lacked jurisdiction to hear Plaintiff's claims because they arose under the Medicare Act. Plaintiff maintains that the trial court was wrong because (1) her claims are not ones for benefits but for the injuries she suffered as a result of the HMO's repeated reluctance to provide rehabilitation treatment, and (2) her claims are based on her contract with the HMO to provide services over and above those required by Medicare.

As the *Redmond* court observed, "the fact that [P]laintiff's causes of action are based on her contractual relationship with [the HMO] does not mean that her claims did not arise under the Medicare Act." (*Redmond* v. *Secure Horizons, Pacificare, Inc., supra*, 60 Cal.App.4th 96, 101.) First, we note that Plaintiff's contract with the HMO specifically discusses the procedures to be followed when Plaintiff has a "dispute, complaint or question related to the provision of services" of her benefit plan. Included in the discussion is the reference to the review provisions of the Medicare Act. Second, although Plaintiff chooses to characterize her complaints as contractually based causes of actions, the fact remains that they are, by necessity, complaints regarding the HMO's initial refusal to provide services. She complains that the HMO initially wrongfully refused to provide her with additional skilled nursing and rehabilitation services, and then only agreed to provide such services after her son objected to its decision. Under the contract, such claims must be resolved under the administrative review process specified in the Medicare Act and therefore these claims arise under the Medicare Act.

Next, while Plaintiff's claims are not actually claims for benefits, because she ultimately received the services, her claims "*are* 'inextricably intertwined' with a claim that she was entitled to [the services] she received." (*Redmond* v. *Secure Horizons, Pacificare, Inc.*, *supra*, 60 Cal.App.4th 96, 102, original emphasis.) Like the plaintiff in the *Redmond* case, Plaintiff argues that her complaint is based on the HMO's conduct with respect to her claim for services. However, "[t]his argument fails because the alleged wrongfulness of [the HMO's] conduct depends on whether [P]laintiff was entitled to [the services received.] The fact that [the HMO] ultimately [provided such services to her] does not necessarily establish that [she] was *entitled* to such [services.]" (*Ibid.*, original emphasis; see *Heckler* v. *Ringer* (1984) 466 U.S. 602, 615-619 [It is of no importance that plaintiffs sought only declaratory and injunctive relief and not an actual award of benefits; their claims were essentially claims for benefits subject to the requirement that they exhaust the administrative review procedures.].) Moreover, as the Redmond court stated, "The administrative review process applies not only to coverage determinations but also to 'any other determination *with respect* to a claim for benefits,' and the Secretary is authorized to order civil money penalties or 'any other remedies authorized by law' if an organization such as defendant fails to provide required services." (*Redmond* v. *Secure Horizons, Pacificare, Inc.*, *supra*, 60 Cal.App.4th 96, 103, original emphasis.)

We also reject Plaintiff's argument that her claims are based on her contract with the HMO to provide services over and above those required by Medicare and thus, outside the provisions of the Medicare Act. As Defendants point out,

this argument ignores the clear language in Plaintiff's contract, "PLAN COVERS ALL SERVICES. YOU PAY Nothing for up to 100 days per Benefit Period for as long as daily skilled nursing care is determined to be medically necessary by your Primary Care Physician *in accordance with Medicare guidelines*." Similarly, the applicability of the Medicare guidelines to all services under the contract is confirmed in the exclusions and limitations portion of the policy which denies coverage for "[a]ll services and items not reasonable and necessary for the diagnosis and treatment of illness or injury as determined by an FHP Plan Physician, *using Medicare guidelines* relying upon professionally recognized standards of practice except as specifically stated elsewhere in your Evidence of Coverage and Disclosure Form."

Further, we note that the language in the Medicare Act authorizes the Secretary to take the necessary action when a health maintenance organization fails to provide medically necessary items and services required under law or under the contract. "If the Secretary determines that an eligible organization with a contract under this section — [¶] (i) fails substantially to provide medically necessary items and services that are required (under law *or under the contract*) to be provided to an individual covered under the contract, if the failure has adversely affected . . . the individual . . . [¶] the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B)." (42 U.S.C. § 1395mm(i)(6)(A), emphasis added.)

Nonetheless, Plaintiff relies on the Ninth Circuit Court of Appeals' decision in *Ardary* v. *Aetna Health Plans of*

California, Inc. (9th Cir. 1996) 98 F.3d 496 and argues that her tort claims are not subject to Medicare's exclusive review provisions. In *Ardary*, the court held that a wrongful death cause of action arising from an organization's denial of Medicare benefits could be brought in state court and did not require exhaustion of the Act's administrative review process because the action was not based on the Medicare Act and did not seek to recover benefits. We reject Plaintiff's argument for two reasons. First, we are not bound by decisions of the federal circuit courts of appeal on federal constitutional questions, even those decisions from our own Ninth Circuit. (*Debtor Reorganizers, Inc.* v. *State Bd. of Equalization* (1976) 58 Cal.App.3d 691, 696; *Alicia T.* v. *County of Los Angeles* (1990) 222 Cal.App.3d 869, 879.) Second, this same argument was made and rejected in the *Redmond* case. We agree with the *Redmond* court's analysis and find the *Ardary* decision equally inapplicable to the facts of this case. (*Redmond* v. *Secure Horizons, Pacificare, Inc.*, *supra*, 60 Cal.App.4th 96, 103-104.)

Likewise, we find Plaintiff's reliance on the decision in *Solorzano* v. *Superior Court* (1992) 10 Cal.App.4th 1135 misplaced. The *Solorzano* case involved the issue of whether individual states could regulate the marketing practices of HMO's when dealing with Medicare beneficiaries. Concluding that federal law did not preempt the states from doing so, the *Solorzano* court stated, "Congress clearly recognized the need for state and local assistance in regulating the marketing of HMO's and other supplemental health care packages to the elderly and disabled and, quite the opposite of intending preemption, appears to have intended a call to the states (and private parties) for all the

help it can get." (*Id.*, at p. 1149.) The ruling in *Solorzano* does not apply to the determination of covered benefits under an HMO insurance plan or Medicare. Instead, it is limited to state regulation of HMOs' marketing practices.

Finally, Plaintiff contends that the HMO's failure to timely notify her of her right to review its benefit decisions precludes it from now asserting those provisions. She cites four cases: *Davis* v. *Blue Cross of Northern California* (1979) 25 Cal.3d 418, *Sarchett* v. *Blue Shield of California* (1987) 43 Cal.3d 1, *Chase* v. *Blue Cross of California* (1996) 42 Cal.App.4th 1142, and *Waller* v. *Truck Ins. Exchange, Inc.* (1995) 11 Cal.4th 1. As Defendants point out, these cases are inapplicable because they involve the application of a contractual arbitration provision. Each case held that a contractual arbitration provision was only enforceable where the arbitration provision was clearly and conspicuously set forth in the contract of insurance, and the insurer notified the insured of the arbitration provision at the time that the insured contested a claims determination. Here, individual healthcare providers cannot waive the requirement that the members participate in the federally mandated administrative review process set forth in the Medicare Act. (*Heckler* v. *Ringer*, *supra*, 466 U.S. 602, 617; *Matthews* v. *Eldridge* (1976) 424 U.S. 319, 328.) Accordingly, we disagree with Plaintiff's contention.

DISPOSITION

The judgment is affirmed. Respondents are to recover their costs on appeal.

Appendix A

NOT FOR PUBLICATION

s/ HOLLENHORST
Acting P.J.

We concur:

s/ RICHLI
J.

s/ WARD
J.

APPENDIX B — NOTICE OF ENTRY OF JUDGMENT DATED DECEMBER 5, 1997 AND FILED DECEMBER 9, 1997

Jon Manzanares (SBN 107249)
Thomas C. Knego (SBN 112636)
KONOWIECKI & RANK
633 West Fifth Street, Suite 3500
Los Angeles, California 90071
Telephone: (213) 229-0990

Attorney for Defendants, FHP, INC.,
incorrectly named as as FHP Healthcare Corporation

SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF SAN BERNARDINO

Case No. SCV 35262

MARY LOUISE O'NEAL,

Plaintiff,

v.

FHP HEALTHCARE CORPORATION, LOMA LINDA FACULTY MEDICAL GROUP, INC., BONNIE BARNES, RECHE CANYON REHABILITATION AND CARE CENTER, CYNTHIA M. GLEASON, AND DOES 1- 100, INCLUSIVE,

Defendants.

NOTICE OF ENTRY OF JUDGMENT

Appendix B

TO ALL PARTIES AND TO THEIR ATTORNEYS OR RECORD HEREIN:

NOTICE IS HEREBY GIVEN that the Honorable John P. Wade sitting in Department 11 of the above-entitled Court, signed an Order for Dismissal of this action on October 15, 1997. Pursuant to *Code of Civil Procedure* Section 581(d), judgment was entered at that time. A conformed copy of Judge Wade's Order is attached to this Notice.

Dated: December 5, 1997 KONOWIECKI & RANK

By: s/ Thomas C. Knego
Thomas C. Knego
Attorney for Defendants,
FHP, INC.

Appendix B

KONOWIECKI & RANK
Jon Manzanares (SBN 107249)
Thomas C. Knego (SBN 112636)
633 West Fifth Street, Suite 3500
Los Angeles, California 90071-2007
Telephone: (213) 229-0990

Attorneys for Defendant,
FHP, INC., incorrectly named as FHP HEALTHCARE CORPORATION

SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF SAN BERNARDINO

CASE NO. SCV 35262

MARY-LOUISE O'NEAL,

Plaintiff,

vs.

FHP HEALTHCARE CORPORATION, LOMA LINDA FACULTY MEDICAL GROUP, INC., BONNIES BARNES, RECHE CANYON REHABILITATION AND HEALTH CARE CENTER, CYNTHIA M. GLEASON, AND DOES 1-100, INCLUSIVE,

Defendants.

ORDER ON DEFENDANT FHP, INC.'S DEMURRER TO PLAINTIFF'S FIRST AMENDED COMPLAINT

Appendix B

Date: September 8, 1997
Time: 8:30 a.m.
Dept.: 11

Trial Date: None

TO ALL PARTIES AND TO THEIR ATTORNEYS OF RECORD:

The Demurrer to Plaintiff's First Amended Complaint brought by Defendant, FHP, INC. and joined in by defendants RECHE CANYON REHABILITATION AND HEALTH CARE CENTER and CYNTHIA M. GLEASON, as well as defendants, LOMA LINDA FACULTY MEDICAL GROUP, INC. and BONNIE BARNES, came on regularly for hearing at 8:30 a.m. in Department 11 of the above-entitled court on September 8, 1997, the Honorable John P. Wade, Presiding.

Plaintiff appeared by her attorney, Jolene Yorba, of Shernoff, Bidart, Darras and Arvin; defendant, FHP, INC. appeared by its attorney, Lynn E. Iba of Konowiecki & Rank; defendants, RECHE CANYON REHABILITATION AND HEALTH CARE CENTER, INC. and CYNTHIA M. GLEASON, appeared by their attorney, Kevin E. McCann of McCann and Carroll; and defendants, LOMA LINDA FACULTY MEDICAL GROUP, INC., and BONNIE BARNES, appeared by their attorney, Christopher Cannon, of La Follette, Johnson, De Haas, Fesler and Ames.

Upon full reconsideration of all points and authorities filed in support of and in opposition to the demurrer, and following oral argument, the court sustained all demurrers without leave to amend.

Appendix B

It is hereby ordered, adjudged and decreed, that the defendants' demurrer to plaintiff's first amended complaint is sustained without leave to amend;

It is further ordered, adjudged and decreed that the plaintiff's First Amended Complaint is therefore dismissed in its entirety.

IT IS SO ORDERED.

Dated: 10-15-, 1997

By: s/ JOHN P. WADE
John P. Wade
JUDGE OF THE SUPERIOR COURT

APPENDIX C — ORDER OF THE SUPREME COURT OF CALIFORNIA FOR THE FOURTH APPELLATE DISTRICT, DIVISION TWO DENYING PETITION FOR REVIEW DATED AND FILED APRIL 28, 1999

Fourth Appellate District, Division Two, No. E021602
S077316
IN THE SUPREME COURT OF CALIFORNIA

MARY-LOUISE O'NEAL,

Appellant

v.

FHP INC. Et Al.,

Respondents

Appellant's petition for review DENIED.

The request for an order directing publication of the opinion is DENIED.

s/ George
Chief Justice

Supreme Court, U.S.
FILED
AUG 26 1999
CLERK

No. 99-183

IN THE
Supreme Court of the United States

MARY–LOUISE O'NEAL,

Petitioner,

v.

FHP, INC., LOMA LINDA FACULTY MEDICAL GROUP, INC. and BONNIE BARNES,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE CALIFORNIA SUPREME COURT

BRIEF IN OPPOSITION FOR RESPONDENT RECHE CANYON REHABILITATION AND HEALTHCARE CENTER, INC.

C. DANIEL CARROLL
Counsel of Record
MCCANN & CARROLL
Attorneys for Respondent Reche Canyon Rehabilitation and Healthcare Center, Inc.
2755 Jefferson Street, Suite 211
Carlsbad, California 92008
(760) 729-3400

QUESTION PRESENTED

The question presented in this Petition for a Writ of Certiorari is whether a medicare beneficiary can maintain a state court action against her health maintenance organization arising from the alleged delay in the provision of benefits [in this case physical therapy following a stroke] without first participating in the administrative review process mandated by the Medicare Act. *See* 42 U.S.C. § 1395mm(c)(5)(A), 42 C.F.R. §§ 417.600-417.638.

Secondary to this issue is the question of whether the facts presented in this matter fall within the *special case* exception to the Medicare administrative review process established by this Court in *Heckler v. Ringer,* 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984).

Respondents RECHE CANYON REHABILITATION AND HEALTHCARE CENTER, INC., and CYNTHIA M. GLEASON respectfully submit that the answer to the first question is in the affirmative, that Petitioner MARY LOUISE O'NEAL was required to participate in the Medicare Act administrative review process, and that her failure to do so results in her attempted state court action being administratively preempted and barred by the resulting lack of subject matter jurisdiction.

Respondents respectfully submit that the answer to the second question is in the negative, and that neither *Heckler* nor the lower court cases decided thereafter are consistent with the conclusion that O'NEAL presents such a *special case* that she is, or should be, exempt from the Medicare Act's administrative review process.

In sum, Respondents respectfully submit that the California Courts' decisions in this matter are sound, that no basis for review by this Court exists, and that O'NEAL's Petition for a Writ of Certiorari must be ***DENIED***.

STATEMENT PURSUANT TO RULE 29.6

Pursuant to Supreme Court Rule 29.6, Respondent RECHE CANYON REHABILITATION AND HEALTHCARE CENTER, INC. states that it is a wholly owned subsidiary of InterWest Medical Corporation, a publicly traded company, with its principal offices in Fort Worth, Texas.

TABLE OF CONTENTS

	Page
Question Presented	i
Statement Pursuant to Rule 29.6	ii
Table of Contents	iii
Table of Cited Authorities	v
Introduction	1
Statement of Facts	1
A. The Parties	1
B. The Events Leading Up to This Claim	2
Statement of the Case	5
I. O'NEAL Was Required To Exhaust Her Administrative Remedies Under The HCFA Review Procedure	6
II. California Case Law Establishes That O'NEAL Was Required To Participate In The HCFA Review Procedure	12
III. The Federal Cases Relied Upon By O'NEAL Are Either Distinguishable Or Inapplicable	17
A. *Ardary* Is Distinguishable	17

Contents

Page

B. *Wartenberg* and *Plocica*, Like *Ardary*, Are Distinguishable 21

C. The Other Federal Cases Cited by O'NEAL Are Inapplicable 24

IV. Public Policy Supports The Preemption Of O'NEAL's Claims 27

Conclusion 29

TABLE OF CITED AUTHORITIES

Page

Cases:

Ardary v. Aetna Health Plans, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408, 138 L. Ed. 2d 174 (1997) ..... *passim*

Berman v. Abington Radiology Associates, 1997 WL 534804 (E.D. Pa. 1997) 24, 25

Bodimetric Health Services v. Aetna Life & Cas., 903 F.2d 480 (7th Cir. 1990) 7, 10, 16, 17

Heckler v. Ringer, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984) ..... *passim*

Plocica v. Nylcare of Texas, 43 F. Supp. 2d 658 (N.D. Tex. 1999) 21, 22, 23, 27

Redmond v. Secure Horizons, 60 Cal. App. 4th 96, 70 Cal. Rptr. 2d 174 (1997) ..... *passim*

Roen v. Sullivan, 764 F. Supp. 555 (W.D. Minn. 1991) 7, 17

Talbot v. Lucy Corr Nursing Home, 118 F.2d 215 (4th Cir. 1997) 24, 25

Wartenberg v. Aetna U.S. Health Care, Inc., 2 F. Supp. 2d 273 (E.D.N.Y. 1998) 21, 22, 23, 27

Page

Wilkins v. Sullivan, 889 F.2d 135 (9th Cir. 1989) .. 7, 17

Winkler v. Interim Health Services, Inc., 36 F. Supp. 2d 1026 (M.D. Tenn. 1999) 24, 26, 27

Zamora-Quezada v. Health Texas, 34 F. Supp. 2d 433 (W.D. Tex. 1998) 24, 25, 26, 27

Statutes:

29 U.S.C. § 794 25

42 U.S.C. § 405(b) 17

42 U.S.C. § 405(g) 6, 8, 9, 17, 24, 30

42 U.S.C. § 405(h) 8, 30

42 U.S.C. §§ 1395, *et seq.* 24

42 U.S.C. §§ 1395c, *et seq.* 6

42 U.S.C. § 1395ff 6, 17

42 U.S.C. § 1395ff(a) 16

42 U.S.C. § 1395hh 6

42 U.S.C. §§ 1395j, *et seq.* 6

Page

42 U.S.C. § 1395mm 6

42 U.S.C. § 1395mm(b)(2) 8

42 U.S.C. § 1395mm(c) 6

42 U.S.C. § 1395mm(c)(5) 6

42 U.S.C. § 1395mm(c)(5)(A) ..... i, 7, 30

42 U.S.C. § 1395mm(c)(5)(B) 16, 17

42 U.S.C. § 1395mm(I)(6) 16

42 U.S.C. § 1983 24

42 U.S.C. § 12182(a) 25

California Insurance Code, Section 790.03 12

Other Authorities:

42 C.F.R. §§ 405.701-405.753 7

42 C.F.R. §§ 405.801-405.877 7

42 C.F.R. §§ 417, *et seq.* 6

42 C.F.R. §§ 417.600-417.638 ..... i, 6, 7

	Page
42 C.F.R. § 417.606	7, 9
42 C.F.R. § 417.606(a)(3)	9
42 C.F.R. § 417.616	7
42 C.F.R. § 417.620	7
42 C.F.R. § 417.634	7
42 C.F.R. § 417.636	7

INTRODUCTION

In a Petition for a Writ of Certiorari rife with hyperbole and misstatements of fact, and founded upon inapplicable statutory and case law, Petitioner MARY-LOUISE O'NEAL ("O'NEAL") seeks to overturn the California Supreme Court's refusal to review the ***unpublished*** Opinion of the California Court of Appeal, affirming the Judgment of the San Bernardino County Superior Court sustaining Respondents' Demurrers to O'NEAL's First Amended Complaint *without leave to amend*. As will be demonstrated herein, O'NEAL's First Amended Complaint was a poorly disguised attempt to re-characterize federal Medicare Act benefits' determinations into common law tort claims. Both the Trial and Appellate Courts saw through this transparent attempt to avoid the Medicare Act's exclusive administrative review process, and correctly rejected O'NEAL's common law tort claims. Notwithstanding O'NEAL's impassioned pleas based upon sympathetically colored facts, both California and federal law required the dismissal of this action. Therefore, O'NEAL's Petition for a Writ of Certiorari must be rejected, and the decisions of California Courts ***AFFIRMED***.

STATEMENT OF FACTS

A. The Parties

O'NEAL is an elderly resident of San Bernardino County, California. [C.T. 230, ¶ 25] O'NEAL receives Medicare benefits which form the principal source of her health care financing.

Respondent FHP HEALTHCARE CORPORATION ("FHP"), is a Health Maintenance Organization ("HMO") which provides health insurance benefits to senior citizens. [C.T. 230, ¶ 26] In or about January 1995, O'NEAL enrolled in the FHP

Senior Plan. [C.T. 234, ¶ 41] As consideration for her enrollment, O'NEAL assigned her Medicare benefits to FHP. [C.T. 235, ¶ 43] A copy of O'NEAL's FHP Senior Plan policy was incorporated by reference into to the First Amended Complaint as Exhibit "A." [C.T. 269-315]

Respondent LOMA LINDA FACULTY MEDICAL GROUP ("LOMA LINDA") was the health care provider selected by O'NEAL under her FHP Senior Plan, and was primarily responsible for administering O'NEAL's benefits under that Plan. [C.T. 231, ¶ 27] Respondent BONNIE BARNES ("BARNES") was the LOMA LINDA case manager responsible for O'NEAL's care. [C.T. 231, ¶ 28]

Respondent RECHE CANYON REHABILITATION AND HEALTH CARE CENTER, INC. ("RECHE CANYON") is a skilled nursing facility. [C.T. 231, ¶ 29] RECHE CANYON contracted with LOMA LINDA to provide skilled nursing care to its patients, one of whom was O'NEAL. Respondent CYNTHIA M. GLEASON ("GLEASON") was a social services person at RECHE CANYON who worked on O'NEAL's case. [C.T. 231, ¶ 30]

B. The Events Leading Up to This Claim

On December 10, 1995, O'NEAL suffered a stroke. [C.T. 236, ¶ 45] O'NEAL was transported to the San Bernardino County Medical Center, where her stroke was confirmed. [C.T. 236, ¶ 45] Later that same day, O'NEAL was transported to Loma Linda Community Medical Center, her FHP plan hospital. [C.T. 236, ¶ 46]

O'NEAL was hospitalized at Loma Linda until December 12, 1995 [C.T. 236, ¶ 47], when she was transferred to RECHE CANYON for rehabilitation. [C.T. 237, ¶ 51] O'NEAL's therapy at RECHE CANYON included occupational, speech and physical therapy. [C.T. 237, ¶ 52]

From December 16, 1995 through December 31, 1995,

O'NEAL received extensive physical therapy and rehabilitation at RECHE CANYON. [C.T. 238, ¶ 56] On January 1, 1996, FHP determined that O'NEAL had made "excellent progress," and was ready for discharge to a convalescent facility. O'NEAL's son, Enos Doyle ("Mr. Doyle"), protested this decision to BARNES. [C.T. 239, ¶ 59] When BARNES refused to reconsider the decision, Mr. Doyle contacted a FHP case manager to request further reconsideration. In the second week of January 1996, FHP's decision to discharge O'NEAL was rescinded. [C.T. 240, ¶ 61] At no time during this process was O'NEAL denied any physical therapy or rehabilitation.

On January 23, 1996, FHP determined that O'NEAL had *plateaued*,[1] and advised Mr. Doyle that it intended to discontinue her therapy and transfer her to a convalescent facility. Mr. Doyle again protested, O'NEAL was reevaluated, and the decision to transfer her to a convalescent facility was revoked. [C.T. 240- 241, ¶ 63] As a result, O'NEAL's rehabilitative care continued throughout the remainder of January 1996. [C.T. 241, ¶ 64]

On January 30, 1996, FHP again determined that O'NEAL should be transferred to a convalescent care facility. [C.T. 241-242, ¶¶ 66-68] In essence, FHP determined that O'NEAL no longer needed skilled nursing care. [C.T. 242, ¶ 68] This was confirmed in the Order of Discharge from RECHE CANYON. [C.T. 242, ¶ 70]

On February 2, 1996, O'NEAL was discharged from RECHE CANYON and admitted into Crestview Convalescent Hospital. [C.T. 242, ¶ 71] It is ***undisputed*** that throughout her stay at RECHE CANYON, O'NEAL was never denied any of the physical therapy or rehabilitative care which she requested

---

[1] In medical parlance, a patient has *plateaued* when the health care provider determines that the patient has become stable, or obtained the maximum recovery by virtue of the medically necessary rehabilitation or treatment.

[C.T. 241, ¶ 54], and that all of this treatment was paid for by FHP. [C.T. 228, ¶ 23-24; Petition 10, 11, 12, 22, 23, 27, 28]

O'NEAL received a physical therapy evaluation at Crestview, and from February 2, 1996 through June 6, 1996, O'NEAL continued receiving restorative nursing assistance and treatment at Crestview. [C.T. 243, ¶ 74]

On June 6, 1996, O'NEAL was evaluated by Dr. Bernard E. Tilton. [C.T. 243, ¶ 24] Dr. Tilton prepared a report which recommended continued physical therapy for O'NEAL. [C.T. 243, ¶ 75] Upon receiving this report, BARNES authorized Crestview to provide increased physical therapy to O'NEAL. [C.T. 244, ¶ 76] Thereafter, to improve the levels of O'NEAL's physical therapy, LOMA LINDA ordered O'NEAL transferred to a new skilled nursing facility, Heritage Gardens, on July 2, 1996. [C.T. 244, ¶ 78] O'NEAL's physical therapy treatment continued at Heritage Gardens until July 18, 1996, at which time FHP and/or LOMA LINDA[2] again determined that O'NEAL had *plateaued*. [C.T. 244, ¶ 79]

At this time, O'NEAL was discharged to her home. In order to continue with O'NEAL's physical therapy, FHP and LOMA LINDA offered to provide a visiting therapist for O'NEAL up to three times per week. [C.T. 244, ¶ 79] At no time was O'NEAL ever denied the necessary rehabilitation or therapy, and all of the rehabilitation and therapy was paid for by FHP. [Petition 10, 11, 12, 22, 23, 27, 28] O'NEAL never sought increased levels of therapy or rehabilitation through the Health Care Financing Administration ("HCFA") administrative review process [See, *infra*, pages 6 – 13] nor did O'NEAL or her son, Mr. Doyle, make any written objection regarding the level of O'NEAL's treatment. Rather, after O'NEAL had fully recovered from her stroke, this litigation was filed..

---

[2] RECHE CANYON had no input whatsoever regarding O'NEAL's health care, treatment, or rehabilitation after she was transferred from its facility to Crestview Convalescent Hospital on February 2, 1996.

STATEMENT OF THE CASE

O'NEAL filed her Complaint on January 13, 1997. [C.T. 1-52] Respondents demurred to the Complaint, alleging that O'NEAL's claims were preempted by the Medicare Act and that the California Courts lacked subject matter jurisdiction to adjudicate O'NEAL's claims. [C.T. 73-91; 92-101; 143-146] The Demurrers were sustained with leave to amend on May 21, 1997. [C.T. 217-218] The Trial Court specifically held that "[O'NEAL] has failed to exhaust her administrative remedies as required by federal statute." [C.T. 218, ¶ 1]

On June 20, 1997, O'NEAL filed her First Amended Complaint. [C.T. 221-324] The First Amended Complaint was ***virtually identical*** to the original Complaint, and contained the same defects. Therefore, Respondents demurred to the First Amended Complaint. [C.T. 325-345; 365-368; 369-400] On September 8, 1997, the Superior Court sustained all of the demurrers *without leave to amend* and entered a Judgment of Dismissal. [C.T. 552-556; 561-562; R.T. 10-12]

On November 7, 1997, O'NEAL filed a Notice of Appeal to the California Court of Appeal. Thereafter, on February 5, 1999, the Court of Appeal filed its Opinion affirming the Trial Court's Judgment of Dismissal. [Petition, Appendix A] O'NEAL next sought review by the California Supreme Court, but her Petition for Review was summarily denied by the Court on April 28, 1999. [Petition, Appendix C] It is from this denial of review that O'NEAL now seeks review by this Court.

I

O'NEAL WAS REQUIRED TO EXHAUST HER ADMINISTRATIVE REMEDIES UNDER THE HCFA REVIEW PROCEDURE

In this case, O'NEAL's claims arise as a direct result of Respondents' benefit determinations under the federal Medicare guidelines. O'NEAL contends that Respondents delayed in providing rehabilitation services to which she believed she was entitled, and seeks emotional distress damages as a result of the alleged delays. Respondents contend that O'NEAL's claims are preempted by the federally mandated HCFA administrative review process, and that having failed to redress her grievances in that process, O'NEAL is jurisdictionally barred, or administratively preempted, from pursuing her state law tort claims. The history and framework of the Medicare program is important to this analysis.

The federal Medicare program is governed by a detailed set of regulations prescribed by the Secretary of Health and Human Services. These regulations are set forth in the Medicare Act [42 U.S.C. § 1395hh] and in Title 42 of the Code of Federal Regulations. 42 C.F.R. § § 417, *et seq*. The Medicare Act applies to and regulates HMOs [such as FHP] that contract with the HCFA to arrange for the provision of medical and hospital services to Medicare recipients enrolled with the HMO. 42 U.S.C. § 1395mm. The HMO must provide its Medicare enrollees with all of the services covered in Medicare Parts A and B [42 U.S.C. § § 1395c, *et seq*. and 1395j *et seq*.] which are available to individuals residing in the geographic area served by the HMO. 42 U.S.C. § 1395mm(c).

The Social Security Act, as amended, and its supporting regulations provide a multi-level administrative review process for parties dissatisfied with the original disposition of their Medicare benefits claims by an HMO. See, 42 U.S.C. § § 405(g), 1395ff and 1395mm(c)(5); 42 C.F.R. § § 417.600 -

417.638. See also, *Bodimetric Health Services v. Aetna Life & Cas.* , 903 F. 2d 480, 483 (7th Cir. 1990). ***The HCFA administrative review process is identical for recipients of Medicare benefits on a private pay basis and for subscribers to Medicare affiliated HMOs like FHP.*** Compare, 42 C.F.R. §§ 405.701 - 405.753, 42 C.F.R. §§ 405.801 - 405.877, and *Wilkins v. Sullivan,* 889 F. 2d 135, 138 (9th Cir. 1989) with 42 U.S.C. § 1395mm(c)(5)(A), 42 C.F.R. §§ 417.600- 417.638 and *Roen v. Sullivan,* 764 F. Supp. 555, 557 (W.D. Minn. 1991).

The administrative review process set forth in 42 C.F.R. 417.600-417.638 applies to all benefit appeals by beneficiaries of Medicare affiliated HMOs. The HCFA process contains six separate steps. They are:

(1) An initial determination of coverage or no coverage by the HMO [42 C.F.R. § 417.606].

(2) If the patient disagrees with the initial determination, the patient can request reconsideration by the HMO [42 C.F.R. § 417.616.].

(3) If the patient still disagrees with the organization's reconsideration decision, the claim is reviewed by a representative of the HCFA [42 C.F.R. § 417.620].

(4) If the patient contests the determination of the HCFA representative, a hearing is held before an Administrative Law Judge [42 C.F.R. § 417.634].

(5) If the patient disagrees with the Administrative Law Judge's decision, the patient can make a final appeal to the HCFA Appeals Council [42 C.F.R. § 417.634].

(6) Finally, if the patient is dissatisfied with the Appeals Council ruling, and if the amount in controversy is $1,000 or more, the patient can bring an action in the District Court against the Secretary of Health and Human Services to contest the benefit determination [42 C.F.R. § 417.636].

In this case, O'NEAL's First Amended Complaint alleges that she received an initial determination which discontinued certain rehabilitation benefits to which she

believed she was entitled. That determination was informally protested by O'NEAL's son, and the requested rehabilitation benefits were continued. O'NEAL ***concedes*** that she received ***all*** of the rehabilitation treatment that she requested, and at no cost to her. [Petition 10, 11, 12, 22, 23, 27, 28; C.T. 228] All of this occurred without the necessity of HCFA review. The congressionally mandated system worked effectively in this case. Pursuant to 42 U.S.C. § 1395mm(b)(2) and 42 U.S.C. § 405(g) and (h), O'NEAL is not entitled to resort to the judicial process. If she desired additional benefits or the imposition of civil penalties against Respondents for the alleged delays in the process, she was required to proceed through the HCFA review process and, if dissatisfied at the conclusion of that process, to proceed in the District Court against the Secretary of Health and Human Services. O'NEAL having failed to do so, the California courts lacked the subject matter jurisdiction to adjudicate her claims against Respondents. Therefore, the dismissal by the Trial Court, the subsequent affirmance by the Court of Appeal, were proper under the law.

The scope of Section 405(g)'s administrative exhaustion requirement was considered by this Court in *Heckler v. Ringer* (1984) 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622 ("*Heckler*"). After analyzing the HCFA administrative review process [*See*, *Heckler v. Ringer, supra*, 466 U.S. at 604-606], Chief Justice Rehnquist held that Section 405(g) is the only avenue for judicial review of benefits determinations, and that the exhaustion of ***all*** steps in the HCFA administrative review process is a prerequisite to judicial jurisdiction for any claim ***arising under*** the Medicare Act. *Id,* at 617. Further, the *Heckler* opinion stated that "Section 405(g) consists of a ***non-waivable requirement*** that a claim for benefits shall have been presented to the Secretary." *Id.* [Emphasis added] Finally, the Court held that the determination of whether a beneficiary's claims are "***arising under***" the Medicare Act must be "***construed quite broadly***." *Id,* at 615.

In the instant matter, there is ***no dispute*** that O'NEAL failed to participate in any step in the HCFA administrative review process prior to the commencement of this litigation. Pursuant to Section 405(g), this non-waivable administrative review requirement constitutes a subject matter jurisdiction bar to O'NEAL's commencement of litigation. *Id,* at 617. Thus, it is clear that the Trial Court correctly granted Respondents' Demurrers, and that the Judgment of Dismissal was properly affirmed by California's Appellate Courts. Further, even assuming *arguendo* that she could avoid this subject matter jurisdiction defect, O'NEAL's claims ***must*** have been filed in the federal courts ***and*** the Secretary of Health and Human Services was an indispensable party to that action.

In her Petition, O'NEAL argues that the HCFA administrative review process is inapplicable because the rehabilitation treatment was ultimately provided by Respondents without any obligation for payment by O'NEAL. [Petition 10, 11, 12, 22, 23, 27, 28] This argument ***misses the mark***, and ignores the plain language of 42 C.F.R. § 417.606 (a)(3) which defines an "organization decision" to include:

> "(3) The HMO's or CMP's refusal to provide services that the enrollee believes should be furnished or arranged for by the HMO or CMP and the enrollee has not received the services outside the HMO or CMP."

O'NEAL's purported common law tort allegations ***directly relate*** to the alleged denial of, or the delay in providing, skilled nursing care, physical therapy, and rehabilitative care. These grievances are specifically covered by the language of Section 417.606, and are subject to the HCFA administrative review process mandated by 42 U.S.C. § 405(g). O'NEAL's attempt to avoid participating in this Congressionally mandated

administrative process is misplaced, and the preemption resulting from her failure to participate is absolute.

Similarly, O'NEAL's argument that her state law claims are collateral to a claim for benefits is misplaced. As the Seventh Circuit held in *Bodimetric Health Services vs. Aetna Life & Cas., supra*, 903 F. 2d 480, 487:

> "A party cannot avoid the Medicare Act's jurisdiction by simply styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharactering their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined."

In sum, O'NEAL was required to participate in the administrative review process. She concedes that she failed to do so. This concession is ***fatal*** to O'NEAL's claim.

Finally, O'NEAL's argument that the benefits which she sought fell within the optional supplemental plan provisions of her FHP Senior Plan and, therefore, were not subject to the Medicare administrative review requirements [Petition 28 - 29] is ***misplaced and misleading***. In her Petition, O'NEAL contends that the determination of whether she was entitled to the subject rehabilitative therapy is governed by the FHP contract, and not by the Medicare Act guidelines. ***This argument ignores the clear language of the FHP insurance contract*** [C.T. 265-319] which provides that while O'NEAL was a patient at a skilled nursing care facility, FHP would provide physical, speech and occupational therapy under the following guidelines:

> "PLAN COVERS ALL SERVICES. YOU PAY nothing for up to 100 days per benefit period for as long as daily skilled nursing care is determined to be medically necessary by your primary care physician ***in accordance with Medicare guidelines***." [C.T. 296]

Similarly, the applicability of the Medicare guidelines to all other services rendered under the FHP policy is confirmed in the "Exclusions and Limitations" portion of the policy which denies coverage for:

> "All services and items not reasonable and necessary for the diagnosis and treatment of illness or injury as determined by an FHP plan physician ***using Medicare guidelines*** relying upon professionally recognized standards of practice except as specifically stated elsewhere in your evidence of coverage and disclosure form." [C.T. 297]

Thus, contrary to O'NEAL's assertions, all of the relevant benefits determinations applicable to O'NEAL's rehabilitation therapy were governed by the Medicare guidelines. Review under the HCFA administrative review process was mandatory. Hence, O'NEAL's First Amended Complaint was properly dismissed by the Trial Court. That Judgment was properly affirmed by the Court of Appeal and the California Supreme Court [through its denial of O'NEAL's Petition for Review], and must again be ***AFFIRMED*** by this Court through the rejection of O'NEAL's Petition for a Writ of Certiorari.

II

CALIFORNIA CASE LAW ESTABLISHES THAT O'NEAL WAS REQUIRED TO PARTICIPATE IN THE HCFA REVIEW PROCEDURE

The focal issue in this case is whether O'NEAL was required to participate in the HCFA administrative review process as a prerequisite to commencing any litigation arising from the alleged delay in providing her with physical and/or occupational rehabilitation/therapy. This precise issue was recently decided by the California Court of Appeal in *Redmond v. Secure Horizons, supra,*60 Cal.App.4th 96 ("*Redmond*"). RECHE CANYON respectfully submits that the *Redmond* decision correctly interprets the federal Medicare statutes, and mandates that the Trial Court's Judgment of Dismissal has been properly ***AFFIRMED*** by the California Appellate Courts.

In *Redmond*, Plaintiff Thelma Redmond brought a bad faith action against Secure Horizons and PacificCare, Inc., her HMOs. Redmond claimed that Secure Horizons had denied her coverage for "life saving surgery." After undergoing the surgery, paying for it herself, and then obtaining full reimbursement from Secure Horizons, Redmond filed a state court action against Secure Horizons for Breach of Contract, Breach of the Implied Covenant of Good Faith and Fair Dealing in violation of *California Insurance Code*, Section 790.03, and intentional and negligent infliction of emotional distress. The causes of action were based upon Secure Horizons' initial denial of Redmond's request for coverage, and its subsequent delay in reimbursing Redmond for her medical expenses. Like O'NEAL herein, Redmond ***conceded*** that (1) she ultimately received all of the medical treatment that she requested from Secure Horizons, and (2) Secure Horizons paid for all of the medical treatment in full. Redmond sought monetary damages for "loss of use" of the monies she expended for the medical services prior to reimbursement by Secure Horizons, emotional

distress damages resulting from the initial coverage denial and the subsequent delay in reimbursement, and attorney's fees and costs incurred in obtaining reimbursement of the medical expenses from Secure Horizons. *Redmond v. Secure Horizons*, *supra*, 60 Cal.App.4th at 99.

Secure Horizons demurred to Redmond's Complaint, arguing that the California courts lacked subject matter jurisdiction because Redmond's claim was one "arising under" the Medicare Act and was subject to the ***exclusive*** HCFA administrative review process. Secure Horizons argued that because Redmond failed to submit to the administrative review process, she was barred from bringing an action for damages. Redmond countered with the argument that she was not required to participate in the HCFA administrative review process because her action was not a coverage or reimbursement case, but rather an insurance bad faith case. *Id.* at 99-100.

The Trial Court granted Secure Horizons' Demurrer without leave to amend, holding that Redmond's "tort and contract claims are inextricably intertwined with the denial of Medicare benefits and are therefore subject to the administrative procedures mandated by the Medicare Act." *Id.* at 100. Redmond appealed.

The Court of Appeal ***affirmed***. The Court identified the dispositive issue as "whether [Redmond's] causes of action were based on a claim which was subject to the exclusive review provisions of the Medicare Act." *Id.* at 100. The *Redmond* Court, like the Trial and Appellate Courts herein, acknowledged that claims which arise under the Medicare Act must be brought before the Secretary of Health and Human Services through the HCFA administrative review process. Judicial review of such claims is available ***only after*** the claimant has pressed the claim through each level of the administrative review process to a ***final*** decision by the Secretary, and even then such review may ***only*** be obtained in

the federal courts. *Id.* at 101. Finally, the *Redmond* Court held that claims which are within the purview of the HCFA administrative review process are ***never*** within the jurisdiction of a state court. *Id*, at 101.

Next, the *Redmond* Court analyzed the crucial question of whether Redmond's claims "[arose] under the Medicare Act." First, the Court considered Redmond's contention that because her claims were based upon her contractual relationship with Secure Horizons, her claims did not arise under the Medicare Act. In rejecting this contention, the Court noted that Redmond's action was based on allegations that Secure Horizons wrongfully denied coverage for her surgery and then wrongfully delayed reimbursement of the expenses for her surgery. The Court concluded that such claims were required to be resolved through the HCFA review process and, therefore, ***arose under*** the Medicare Act. *Id.* at 101-102.

The Court then considered Redmond's argument that her causes of action were not actually a claim for benefits, since she had already received all of the medical treatment and had obtained full reimbursement from Secure Horizons for her expenses. This argument was also rejected, with the Court holding that irrespective of the fact that Redmond had received the services and been reimbursed for her costs, her breach of contract and bad faith causes of action to recover consequential damages arising out of the delay in providing or paying for these services were "inextricably intertwined" with the claim that she was entitled to receive the services in the first place. *Id.* at 102.

The Court also rejected Redmond's argument that her Complaint was not based on her entitlement to benefits but, rather, on Secure Horizons' "conduct with respect to her claim for benefits," noting that "the alleged wrongfulness of [Secure Horizons'] conduct depends on whether [Redmond] was entitled to payment of her claim." *Id*, at 102.

Finally, the Court considered Redmond's argument that while the administrative review process provides a remedy for adverse coverage determinations, it does not provide a remedy for

wrongful denial or delay in paying a claim. *Id,* at 102-103. In rejecting this argument, the Court of Appeal stated:

> "The administrative review process applies not only to coverage determinations but also to any other determination *with respect to* a claim for benefits, and the Secretary [of Health and Human Services] is authorized to order civil money penalties or any other remedies authorized by law if an [HMO] fails to provide required services. If [Redmond] had pressed her claim through the administrative review process and established that the [HMOs] initially wrongfully denied coverage, the Secretary could have found that [the HMOs] had failed to provide required services. The Secretary would then have been authorized to remediate the harm which arose from this conduct prior to [the HMOs'] ultimate reimbursement of [Redmond's] claim. **[Redmond's] contention that she had been injured by the [HMOs'] initial denial and subsequent delayed payment of her claim was a claim which the Secretary was authorized to resolve because it required a determination with respect to [her] claim for benefits.**"
>
> *Id*, at 103 [Emphasis added].

In essence, the *Redmond* Court's analysis was virtually identical to the reasoning of the courts herein in rejecting O'NEAL's claims. O'NEAL has raised, both in the trial court and on appeal, virtually identical arguments to those proffered by the Plaintiff in *Redmond*. As an example, O'NEAL argues that her claims are not subject to the HCFA administrative review process because "the Complaint nowhere claims that rehabilitation care was not *ultimately* provided. Nor is there any allegation that O'NEAL has any further obligation for payment of the

rehabilitation care." [Petition 10, 11, 12, 22, 23, 27, 28] Contrary to O'NEAL's contentions, the fact that the services were ultimately provided and payment therefor made by FHP does not remove the claim from the HCFA review process. Rather, the question is whether the claims raised by O'NEAL are ***inextricably intertwined*** with the provision or denial of Medicare benefits. *Id,* at 101-102; See also, *Bodimetric Health Services v. Aetna Life & Cas., supra*, 903 F.2d at 487.

In this case, O'NEAL's claims are ***inextricably intertwined*** with her claim for benefits. O'NEAL's claims cannot succeed on any cause of action ***unless*** O'NEAL establishes that she was entitled to receive the rehabilitation treatment at issue. That determination is squarely within the purview of the HCFA, and *Heckler*, *Bodimetric* and *Redmond* teach that the review of the denial or delay in provision of that treatment ***must*** first be obtained through the HCFA review process.

Likewise, O'NEAL argues, as did Redmond, that her consequential damages cannot be remediated through the HCFA process. [Petition 21 - 23] In so doing, O'NEAL ignores the clear language of 42 U.S.C. § 1395 mm (I)(6) providing the Secretary of Health and Human Services with the express power "to impose civil money penalties, suspension of enrollment of individuals or suspension of payment to the organization" against any HMO that fails to provide medically necessary treatment. Likewise, O'NEAL ignores the *Redmond* Court's holding that the imposition of such penalties by the Secretary of Health and Human Services provides an ***adequate remedy*** for the patient. *Redmond v. Secure Horizons, supra,* 60 Cal.App.4th at 103 [Emphasis added].

Finally, O'NEAL's argument that the *Redmond* Court misquoted the applicable Federal Statutes through the use of ellipses is mistaken, at best. [See, Petition 20 - 21] Clearly, the *Redmond* Court mis-cited the applicable federal statutes when it referred to 42 U.S.C. § 1395ff(a) in its Opinion [See, *Redmond v. Secure Horizons*, *supra*, 60 Cal. App. 4th at 101]. Obviously, this mis-citation was a typographical error. The correct citation is 42 U.S.C. §1395mm(c)(5)(B), and is cited throughout the *Redmond* Opinion, including twice in the same paragraph where the mis-

citation referenced by O'NEAL appears. It is clear that while section 1395ff applies to the administrative review of non-HMO claims, section 1395mm controls administrative review of HMO claims. See, *Roen vs. Sullivan, supra*, 764 F. Supp. at 561. ***The two processes are identical***. They are merely set forth in different sections of the controlling statute. O'NEAL's reliance upon this obvious typographical error in the *Redmond* Opinion is appalling.

In sum, *Redmond* is squarely on point, both factually, procedurally, and legally, with the instant matter. The *Redmond* Court clearly and unequivocally held that actions for bad faith coverage determinations and breach of contract arising out of an HMO's failure to properly adjust a medical benefits claim, or any delay inherent therein, are preempted by the HCFA administrative review process. The *Redmond* decision is in accord with the controlling federal statutes [42 U.S.C. §1395mm(c)(5)(B); 42 U.S.C. § 405(b); 42 U.S.C. § 405(g)] and cases [*Heckler*, *Roen*, *Wilkins* and *Bodimetric*] in this area of the law. In light of this holding, it is clear that the Trial Court's Order sustaining Respondents' Demurrers *without leave to amend* was proper. There is no basis or reason for review by this Court.

III
THE FEDERAL CASES RELIED UPON BY O'NEAL ARE EITHER DISTINGUISHABLE OR INAPPLICABLE

A. *Ardary* Is Distinguishable

O'NEAL'S argument that her claims are exempt from the HCFA administrative review process is based primarily upon *Ardary v. Aetna Health Plans*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S.Ct. 2408, 138 L.Ed.2d 174 (1997). [Petition 13 - 17] The *Ardary* decision and reasoning was expressly rejected by the California court in *Redmond* [*Redmond v. Secure Horizons, supra*, 60 Cal.App.4th at 103-104], and this rejection was based upon a sound analysis of the controlling federal cases and statutes. *Ardary* is similarly inapplicable to the instant appeal.

In *Ardary*, Cynthia Ardary suffered a heart attack. She was taken to Bear Valley Community Hospital, an approved facility under her Aetna Health Care plan, for emergency treatment. However, Bear Valley Hospital had neither intensive nor cardiac care facilities. Mrs. Ardary's Aetna plan physician recommended that she be transported by airlift transportation to Loma Linda University Medical Center, the nearest hospital having the necessary cardiac care facilities. However, Mrs. Ardary's HMO, Arrowest Physicians Association, refused to authorize the airlift. Mrs. Ardary died a few hours later at Bear Valley Hospital. *Ardary v. Aetna Health Plans, supra*, 98 F.3d at 497 - 498.

Mrs. Ardary's husband and children filed a state law wrongful death action against Aetna and Arrowest. The HMO Defendants removed the case to federal court, and then moved to dismiss on the ground that the Ardarys failed to participate in the HCFA administrative review process. The District Court granted the Motion to Dismiss, and the Ardarys appealed.

As the Ninth Circuit noted, the *Ardary* facts presented a *thorny jurisdictional question* – "Does the Medicare Act, which provides for exclusive administrative review of all claims 'arising under' that Act, apply to preclude the heirs of a deceased Medicare beneficiary from bringing state law claims for wrongful death against a private Medicare provider . . . ? " *Id,* at 499.

In holding that the Ardarys' claims were not within the purview of the HCFA administrative review process, the Ninth Circuit noted that "in certain special cases, deference to the Secretary's conclusion as to the utility of pursuing the claim through administrative channels is not always appropriate." *Id,* at 500 [citing *Heckler v. Ringer, supra*, 466 U.S. at 618]. Ultimately, the Ninth Circuit concluded that the Ardarys' claims were *not arising under* the Medicare Act because "[Mrs. Ardary's] death cannot be remedied by the retroactive authorization or payment of the airlift transfer." *Id.*, at 500. Therefore, the Ninth Circuit reversed the District Court's Order of Dismissal and remanded the case for further proceedings.

Ardary is a "special case." Unlike the instant matter, the *Ardary* claims were not brought by a Medicare beneficiary but,

rather, by the heirs of a person who died because she was ***totally denied*** the necessary emergency medical treatment. In fact, given the timing between the denial of the transfer and Mrs. Ardary's death, Mrs. Ardary and her family could not have participated in the HCFA administrative review process. By contrast, O'NEAL ***concedes*** that she was ***never*** denied the necessary treatment and merely asserts that Respondents delayed in the provision of some treatment. Moreover, O'NEAL's treatment lasted many months. Thus, O'NEAL had ample time and opportunity to participate in the HCFA administrative review process. Clearly, O'NEAL does ***not*** present a *special case* like was presented in *Ardary*.

Importantly, the *Ardary* analysis was *rejected* in *Redmond*.

> "We find *Ardary* distinguishable. In *Ardary*, the Ninth Circuit acknowledged that the United States Supreme Court had mandated in [*Heckler*] that the scope of the claims to which the administrative review process applied should be interpreted 'broadly' (*Ardary, supra*, at p. 500). However, the Ninth Circuit relied on a narrow exception carved out by the United States Supreme Court which permitted the exclusion of 'certain special cases' from the requirement that the claim be pursued 'through administrative channels' where these 'special' cases involved claims that could not be remediated through the administrative process. (*Ibid.*) Since the death of the health plan beneficiary in *Ardary* could not be remediated through pursuit of a posthumous coverage or benefits claim through the administrative process, the Ninth Circuit held that the administrative review process was inapplicable to the wrongful death cause of action. (*Ibid.*) Hence, the claim could be brought in state court. (*Id.* at pp. 500-501.)

> Whether or not we agree with the Ninth Circuit's resolution of the issue posed in *Ardary*, *Ardary*'s holding is not applicable here. This case, unlike *Ardary*, does not involve a claim which is so 'special' that it could not have been remediated by pursuit of a claim through the administrative review process. **Delays in the reimbursement of claims are commonplace, and the injuries allegedly suffered by [Redmond] are not so 'special' that she falls within the narrow exception to the otherwise universal requirement that the administrative review process must be pursued prior to any judicial review. Unlike the beneficiary in Ardary, [Redmond] had the distinct advantage of obtaining payment of her benefits claim without having had to avail herself of the lengthy administrative review process. The exceptional circumstances present in Ardary are not present here."**
>
> *Redmond v. Secure Horizons, supra*, 60 Cal.App.4th at 103-104 [Emphasis added].

The *Redmond* Court's reasoning in distinguishing *Ardary* is squarely applicable here. Like Redmond, O'NEAL received all of the treatment to which she was entitled and all of that treatment was paid for by Respondents. [Petition 10, 11, 12, 22, 23, 27, 28] Moreover, O'NEAL was not required to avail herself of the HCFA administrative review process to obtain the necessary treatment/payments; rather, FHP voluntarily provided all of the necessary treatment in response to verbal requests for reconsideration by O'NEAL's son. As the *Redmond* Court held, these facts do not present "the *exceptional circumstances* necessary to fit within the *narrow exception* for *special cases* carved out by the Supreme Court in *Heckler*." *Redmond v. Secure Horizons, supra*, 60 Cal.App.4th at 103-104. Therefore, *Ardary*

is factually and legally distinguishable, and is inapplicable to the instant matter. The Trial Court correctly dismissed O'NEAL's claims. No basis for review by this Court exists.

B. *Wartenberg* and *Plocica*, Like *Ardary*, Are Distinguishable

Two other federal cases relied upon by O'NEAL – *Wartenberg v. Aetna U.S. Health Care, Inc.*, 2 F.Supp.2d 273 (E.D.N.Y. 1998) and *Plocica v. Nylcare of Texas*, 43 F.Supp.2d 658 (N.D. Tex. 1999) – are factually and procedurally analogous to *Ardary* and, like *Ardary*, are distinguishable from this case.

In *Wartenberg*, Betty Lieberman was enrolled in a HMO plan administered by Aetna. On Thanksgiving in 1996, Lieberman was admitted to a hospital emergency room with a severe case of pneumonia. She remained in the hospital for six days. Before she recovered from her illnesses, and although she was in no condition to be discharged, Lieberman was discharged from the hospital to a nursing facility where she received skilled care. Three days after her admission to the skilled nursing facility, Lieberman was discharged from the facility on instructions from Aetna's plan physician. After being at home for less than one week, Lieberman was readmitted to the hospital in critical condition. Despite her grave condition, Lieberman was once again quickly discharged from the hospital and readmitted to a skilled nursing facility. Within 48 hours, she was returned to the hospital in acute respiratory distress, where she was attached to a respirator and placed in the Intensive Care Unit. Two weeks later, Lieberman died. *Wartenberg v. Aetna U.S. Health Care, Inc.*, *supra*, 2 F. Supp.2d at 273.

Following Lieberman's death, her nephew, Bernard Wartenberg, sued Aetna alleging that Aetna caused Lieberman's death by transferring her from hospital to hospital, from facility to facility, and by making imprudent medical decisions on her behalf. Claiming medical malpractice arising from his aunt's treatment, Wartenberg sought recovery of burial costs and punitive damages. *Id*, at 274.

Aetna moved to dismiss the case based upon Lieberman's failure to participate in the HCFA administrative review process. In ruling on this motion, the District Court framed the *decisive issue* as whether the wrongful death claims arose under and, therefore, were preempted by the Medicare Act.

Citing this Court's decision in *Heckler*, the District Court noted that if the claim was wholly collateral to a claim for benefits, and if the Plaintiff made a colorable showing that his injury could not be remedied by the retroactive provision of benefits, then participation in the administrative process would not be required. *Id.* at 275. To resolve this issue, the *Wartenberg* Court relied heavily upon the Ninth Circuit's reasoning in *Ardary*. After discussing the *Ardary* Court's reasoning, the *Wartenberg* Court concluded that because Wartenberg was only suing for damages stemming from his aunt's wrongful death, the claim was not *inextricably intertwined* with a claim for benefits, *Id.* at 277. Accordingly, Aetna's Motion to Dismiss was denied. No appeal was taken.

Plocica, like *Ardary* and *Wartenberg,* is also a wrongful death case. Joe Plocica suffered from severe and varying bouts of depression. He had attempted suicide on a number of occasions. Plocica was being treated for this condition by his personal physician, Dr. Eudaly, through his HMO, Nylcare of Texas. *Plocica v. Nylcare of Texas, supra*, 43 F.Supp.2d at 663.

On June 25, 1998, Plocica was admitted to the hospital following an overdose of prescription medication. The following day, Plocica was transferred to the psychiatric ward of another hospital, where he remained until he was discharged by order of his HMO on July 8, 1998. The discharge was made over the written objections of Plocica's physician, Dr. Eudaly.

The following day, Plocica ingested a half gallon of antifreeze in yet another suicide attempt. This time, Plocica was successful. He died eight days later. *Id,* at 663.

Plocica's heirs sued Nylcare and Dr. Eudaly for wrongful death, alleging that Plocica received an "inadequate quality of care and treatment" from his HMO and his treating physician. *Id,* at 664. Nylcare and Dr. Eudaly removed the case to the District

Court based upon the provisions of the Medicare Act. The Plocica heirs then moved to remand the case to the Texas state court, arguing that they were not required to participate in the Medicare review process, and that the case should proceed in the state court on their common law wrongful death claim.

After discussing and analyzing the *Ardary* and *Wartenberg* decisions, the *Plocica* Court granted the motion to remand. The Court held that the heirs' wrongful death claims were not subject to the Medicare review provisions, concluding:

> ". . . The Plocica's assert that '[p]ursuing the administrative Medicare appeal process, the remedy which defendants appear to be arguing for, would be a ***futile act*** since Joe Plocica is dead.'"

Id, at 663 - 664 [Emphasis added].

Wartenberg and *Plocica*, like *Ardary*, fall within the narrow, ***special case*** exception identified in *Heckler*. In *Ardary*, *Plocica* and *Wartenberg*, the plaintiffs' claims sounded in wrongful death. Likewise, in each of these cases the Plaintiffs' decedents died rapidly, precluding their participation in the HCFA administrative review process. Thus, to reject the *Ardary*, *Wartenberg* and *Plocica* claims based upon the administrative preemption doctrine would have deprived the Plaintiffs in those cases of any remedy whatsoever.

The instant matter is factually, procedurally, and legally distinguishable from *Ardary*, *Wartenberg* and *Plocica*. O'NEAL has successfully recovered and is still alive nearly four years after the onset of her stroke. Further, unlike the patients in *Ardary*, *Wartenberg* and *Plocica*, O'NEAL was ***never*** denied any medical treatment. In fact, she ***concedes*** that she received ***all*** of the treatment to which she was entitled ***and*** that FHP paid for ***all*** of that treatment. [Petition 10, 11, 12, 22, 23, 27, 28]. In a nutshell, O'NEAL's claims arise solely from the fact that she believes that

the determinations of whether the benefits at issue were covered under her FHP medical plan were unnecessarily delayed.

O'NEAL's claims are *inextricably intertwined* with her claim for benefits. If FHP was correct in assessing O'NEAL's benefit determinations, then her claim fails because she was not entitled to receive the services at issue. If the services at issue were covered by the Medicare guidelines, then O'NEAL's claim fails because of the administrative preemption doctrine. ***In either case, the threshold issue is whether the rehabilitative therapy in question was covered under the Medicare guidelines***. Pursuant to 42 U.S.C. § 1395, *et seq.*, that decision is exclusively confined to the HCFA administrative review process, and the final determination thereof must be made by the Secretary of Health and Human Services. Since O'NEAL failed to participate in that process, the California courts lacked the subject matter jurisdiction to entertain her claims. 42 U.S.C. § 405(g); *Redmond v. Secure Horizons, supra*, 60 Cal.App.4th at 104.

C. The Other Federal Cases Cited by O'NEAL Are Inapplicable

O'NEAL also relies upon four other federal cases – *Talbot v. Lucy Corr Nursing Home*, 118 F.2d 215 (4th Cir. 1997), *Berman v. Abington Radiology Associates*, 1997 WL 534804 (E.D. Pa. 1997), *Zamora-Quezada v. Health Texas*, 34 F.Supp.2d 433 (W.D. Tex. 1998), and *Winkler v. Interim Health Services, Inc.*, 36 F.Supp.2d 1026 (M.D. Tenn. 1999). As will be shown herein, each of these cases in inapplicable to the case at hand.

Talbot was an action under the residents' rights protections of 42 U.S.C. § 1983. Talbot alleged that she had been wrongfully evicted from the defendants' nursing care facility because of her complaints about her living conditions and the quality of her care. *Talbot v. Lucy Corr Nursing Home*, *supra*, 118 F.2d at 217. The defendants moved to dismiss, arguing that Talbot had failed to exhaust her ***state law*** administrative remedies. *Id*, at 218. The Medicare Act's administrative review process and the preemption created thereby were not even raised by the

defendants. In fact, the District Court ***expressly stated*** that the Medicare Act's administrative exhaustion requirement was inapplicable to the plaintiffs' claims arising from her eviction. *Id.* at 219, *fn.* 1. *Talbot* has no application to this case.

Berman is likewise inapplicable. Berman was a medical malpractice action in which Berman sued her physicians for misdiagnosing her breast cancer. The sole allegations of the Complaint were that Berman's physicians were professionally negligent in her care, and that their employer was negligent in their hiring practices and in the monitoring of their physicians' conduct. *Berman v. Abington Radiology Associates, supra*, 1997 WL 534804, 2. No claims were made that any benefits were denied or withheld, nor were any Medicare Act standards at issue. In the end, the District Court held that malpractice claims against a physician do not *arise under* the Medicare Act when the only question is whether the treatment at issue was properly rendered. *Id.* at 4. No such claims were alleged by O'NEAL herein. Thus, *Berman* provides no support for her position.

O'NEAL's reliance on *Zamora-Quezada* is likewise misplaced. *Zamora-Quezada* was an Americans with Disabilities Act [42 U.S.C. § 12182(a)] ("ADA") and Rehabilitation Act [29 U.S.C. § 794] claim alleging that patients were denied certain items of care based upon their levels of disability. The defendants moved to dismiss the claims based upon the patients' failure to participate in the Medicare administrative review process. After considering the parties' arguments, the District Court held that the Medicare administrative review process was inapplicable because the issue of the plaintiffs' entitlement of benefits under their Medicare coverage was not raised. *Zamora-Quezada v. Health Texas, supra*, 34 F.Supp.2d at 439 - 440. As the Court stated:

> "The amended complaint reveals plaintiffs are not seeking Medicare benefits. The standing and the substantive basis for their claims is not the Medicare Act. Instead, plaintiffs allege defendants engaged in a practice of discouraging the disabled from seeking treatment in violation of the ADA

> and Rehabilitation Act. These theories have their genesis in illegal discrimination and are not related to the furnishing of Medicare benefits while plaintiffs were enrolled with Humana."

Id. at 439 - 440.

Zamora-Quezada is to be contrasted with O'NEAL's claims. O'NEAL's claims are directly related to her entitlement to the benefits in question, and she seeks to recover damages for the alleged delay in providing those benefits. If O'NEAL was not entitled to the benefits, her claims fail on a substantive level. Thus, both the standing and the substantive basis for O'NEAL's claims is in the Medicare Act. Based upon this distinction, *Zamora-Quezada* in inapplicable to O'NEAL's claims

Finally, *Winkler* is not only inapplicable, it supports Respondents' position. The *Winkler* plaintiffs alleged that they were ***totally denied*** benefits based upon the level of their disabilities. Like the plaintiffs in *Zamora-Quezada*, the *Winkler* plaintiffs sought relief under the Rehabilitation Act and alleged ancillary state law damage claims. *Winkler v. Interim Health Services, Inc., supra*, 36 F.Supp.2d at 1027.

The defendants moved to dismiss the Winklers' claims, alleging a lack of subject matter jurisdiction because the plaintiffs had failed to proceed through the Medicare Act's administrative review process. After reviewing this Court's reasoning in *Heckler*, the District Court denied the motion, holding that where the services are ***totally denied***, the Medicare administrative review process is inapplicable. *Id.* at 1028.

Thus, the distinction between O'NEAL's claims and those of the plaintiffs in *Winkler* is that O'NEAL was never denied any services. Therefore, her claims are subject to the administrative review requirements of the Medicare Act. Because the *Winkler* plaintiffs were totally denied the benefits which they sought, and because their claims were alleged under the Rehabilitation Act [which contains no administrative review requirements], they

were not subject to the Medicare Act's subject matter jurisdiction/preemption requirements.

In sum, O'NEAL seeks to improperly expand *Ardary*, *Wartenberg*, *Plocica* and the other federal court decisions beyond their narrow parameters. O'NEAL fails to cite any case where a patient [or their heirs] has been allowed to pursue state law remedies against an HMO where [1] they did not die prior to having the opportunity to participate in the Medicare review process [*Ardary*, *Wartenberg* and *Plocica*], or [2] the claim was based upon a federal statute [e.g. ADA or Rehabilitation Act] which has no administrative review requirement [*Zamora-Quezada* and *Winkler*]. As such, the California courts properly dismissed O'NEAL's claim. There is no basis for review by this Court.

IV
PUBLIC POLICY SUPPORTS THE PREEMPTION OF O'NEAL'S CLAIMS

RECHE CANYON respectfully submits that, in addition to the statutory and case law authority compelling the rejection of O'NEAL's claims, public policy also mandates this result. O'NEAL, like tens of millions of other elderly Americans, receives her basic medical treatment through the federally funded and supervised Medicare program. The aim of this program is to provide efficient, medically necessary care to the elderly at a reasonable cost. In order to achieve this result, Congress and the Secretary of Health and Human Services have adopted guidelines for the cost of most medical procedures, and have determined that many procedures are not covered by the Medicare program. The task of applying the Medicare guidelines, in most cases, falls upon the HMOs and, more particularly, the individual HMO physicians. To ensure that the process is orderly and cost effective, Congress has adopted a streamlined administrative review process.

In this action, O'NEAL seeks to circumvent that administrative process. In essence, she contends that because the services she desired were not provided promptly enough, or as

frequently as she desired, she should be entitled to sue her caregivers for money damages for misapplying the Medicare statutes or applying them too slowly. O'NEAL raises these claims notwithstanding the fact that she actually received ***all*** of the medical treatment which she sought.

If claimants such as O'NEAL are allowed to proceed in the courts without first participating in the HCFA administrative review process, HMOs, medical professionals and insurance companies will be besieged with claims. Every time a patient believes they are entitled to a treatment, or they do not receive a requested treatment immediately, they will sue or threaten to sue. The interim result will be chaos; the end result will be that medical professionals and insurance companies will refuse to participate in the Medicare system. At bottom, America's elderly and infirm will be hard-pressed to find quality medical treatment on anything other than a *private pay* basis. This is not a desired result. As Chief Justice Rehnquist stated in *Heckler*:

> "In the best of all worlds, immediate judicial access for all of these parties might be desirable. But Congress, in Section 405(g) and Section 405(h), struck a different balance, refusing declaratory relief and requiring that administrative remedies be exhausted before judicial review of the Secretary's decisions takes place. **Congress must have felt that cases of individual hardship resulting from delays in the administrative process had to be balanced against the potential for overly casual or premature judicial intervention in an administration system that processes literally millions of claims every year. If the balance is to be struck anew, the decision must come from Congress and not from this court."**
>
> *Heckler v. Ringer, supra*, 466 U.S. at 627. [Emphasis added]

As *Heckler* teaches, Congress has recognized that the effect of government subsidized medicine is that individual patients will occasionally be required to forego some of their personal preferences in exchange for the common good, *to wit*: efficient and cost-effective medical treatment for the masses. Congress recognized this fact when it limited the Medicare beneficiaries' right to institute private actions against HMOs arising out of benefit determinations, and imposed the cost-effective HCFA administrative review process.

This process is beneficial to the Courts, as well. The HCFA administrative review process is designed to handle benefits determination reviews promptly, in most cases within a few weeks. The streamlined process is administrative in nature, does not require attorneys, and is supervised by a neutral, independent third party – the Secretary of Health and Human Services. By contrast, if claimants such as O'NEAL are permitted to pursue their claims in the Courts, the claims will take a year or more to resolve, will require attorney participation on all sides, and will be extremely expensive for all concerned. In addition to the congestion which this will add to the Courts, such litigation might financially collapse HMOs and/or health insurance carriers.

In sum, the relief sought by O'NEAL herein is detrimental to all concerned except O'NEAL. O'NEAL had the opportunity to seek redress of her claims through the HCFA administrative review process, and elected not to participate. Public policy dictates that she should not later be entitled to commence litigation after ignoring this statutorily prescribed remedial process.

CONCLUSION

Pursuant to the Medicare Act, O'NEAL's claims fall squarely within the purview of the HCFA administrative review process. Through that process, O'NEAL could have obtained a determination as to whether the rehabilitation treatment and therapy which she desired was a covered benefit for which FHP was required to pay, and also could have pursued civil, monetary

and administrative remedies against Respondents arising from the alleged delay in processing her claims. O'NEAL voluntarily elected not to participate in this administrative review process. Having done so, O'NEAL's attempt at judicial litigation is precluded both by the Medicare Act [42 U.S.C. 1395mm(c)(5)(A); 42 U.S.C. § 405(g) and (h)] and federal and California case law. Therefore, the Trial Court properly sustained Respondent's Demurrers to O'NEAL's First Amended Complaint *without leave to amend*, and that Judgment was correctly affirmed by the California Appellate Courts. There is no legal or public policy basis for this Court to review the California Courts' decisions.

WHEREFORE, Respondents RECHE CANYON REHABILITATION AND HEALTHCARE CENTER, INC. and CYNTHIA M. GLEASON respectfully request that the instant Petition for a Writ of Certiorari be ***DENIED***, and that Respondents be awarded their costs on appeal.

Respectfully submitted,

C. DANIEL CARROLL
Counsel of Record
MCCANN & CARROLL
Attorneys for Respondent
Reche Canyon Rehabilitation
and Healthcare Center, Inc.
2755 Jefferson Street, Suite 211
Carlsbad, California 92008
(760) 729-3400